MIDWIVES' EXPERIENCES OF WORKING WITH HIGHLY ANXIOUS

CHILDBEARING WOMEN

by

Maureen Elizabeth Hammond

A thesis submitted to the Victoria University of Wellington

in partial fulfilment of the

requirements for the degree of

Master of Arts (Applied)

in Midwifery

Victoria University of Wellington

2005

ABSTRACT

Anxiety is a normal human phenomenon. It is fundamental to our survival as a species, allowing us to adjust and plan for the future and prompts us to seek help and security from others. High levels of anxiety during childbearing are associated with poor fetal development, behavioural/emotional problems in children and adolescents, prolonged labours, increased obstetric intervention, impaired lactogenesis and bonding problems.

Working with highly anxious childbearing women can be a challenging experience for independent lead maternity care midwives. This qualitative investigation guided by the principles of feminist research examined four independent midwives experiences of working with highly anxious childbearing women. Data were collected by interview, and thematic analysis found three themes that encapsulated the experience. The resultant themes were of: 1) challenging partnerships, 2) making a difference and 3) realising own limitations.

The midwives, while very committed to their highly anxious clients, experienced considerable stress while endeavouring to provide effective care. This stress is of concern to midwives and midwifery as it makes midwives vulnerable to burnout. Given the damage that high levels of unchecked anxiety have on childbearing women and their families, midwifery has to look for safe and effective ways to work with these women.

Recommendations for practice are based around negotiating boundaries to the midwife-client relationship, increased help and support for midwives, especially clinical supervision, better midwifery education, and continuous professional development in relation to maternal mental health, and properly resourced and funded maternal mental health services.

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

Midwifery has been a wonderful career choice for me. I have felt privileged to have been involved in the sacred and creative process that women and their families go through with the birth of a new human being. I enjoyed the maternity component of my general and obstetric nursing hospital training (1973-1976) and after four years of general nursing did my midwifery training in a hospital in England in 1980. I have been working as a midwife both in hospitals and the community ever since.

We, as midwives, have a vital role to play in society. We have an opportunity to make a difference in the success of our client's adaptation to and success at parenting. I agree with Page (2000) when she says, "in her everyday and intimate connection with birth, the midwife is the guardian of one of life's most important events, possibly the most important one of our lives and of our society" (p. 1). To build a strong and healthy society I believe that it is essential to build strong healthy family units and therefore to get parenting right at the start is vital. It is this belief that sustains me in my practice.

I developed an interest in working with women who appeared very anxious or distressed early in my midwifery career. As a new midwife in the 1980s I worked in a postnatal ward in a base hospital and I began to be asked to work with women who the other staff would rather not work with because their behaviour was perceived as 'very needy and demanding'. These women were often labelled 'difficult' clients. I then became thought of as 'good with difficult clients' and the more highly anxious women I cared for the more I was allocated. I enjoyed this work and while some of the women were challenging to care for, I met some wonderful women and their families over time and gained a lot of experience with women suffering from anxiety and distress.

In the 1990s, while I was working in the community doing postnatal care, I again encountered women who were anxious and needy. When you work with anxious women who need and demand a lot of input in the hospital setting you go home at the end of the shift and are able to recharge the batteries. However, when you work in the community and your client is highly anxious and requiring a lot of support and information, it is not so easy to manage when you are on a pager or cell phone and they have access to you 24 hours a day, seven days a week.

While I am currently employed as a core midwife in a maternity hospital, when talking with Lead Maternity Care (LMC) midwife colleagues about their day-to-day work,

some have shared with me the difficulties they are having working with women who are anxious, distressed, and demanding a lot of information, support and time. When working with the majority of women over the last 24 years, I have been able to form a professional working relationship, similar to that described by Karen Guilliland and Sally Pairman (1995) as 'partnership'. Guilliland and Pairman (1995) describe the principles that are inherent within this partnership as, "individual negotiation, equality, shared responsibility and empowerment, informed choice and consent" (p. 44). There were clients with whom I have not been able to form a partnership. One client in particular, who I shall refer to as Maree (pseudonym), left a lasting impression on me.

Maree was about 20 weeks pregnant when I met her. After a long and intense interview she asked me to follow her up postnatally at home. She wanted an Obstetrician to do her antenatal care and delivery which meant booking into a base hospital out of our area for intrapartum care. As the pregnancy progressed she became increasingly anxious. She rang me constantly and queried the advice that the obstetrician gave her. She questioned me if she saw me out and about in the community. I even found her waiting for me outside my children's school because she had something to ask me. She continued to do this despite the fact that I told her constantly that I was only supposed to do her postnatal care. I found this very stressful. I voiced my concern to the obstetrician about Maree's mental health but he did not feel she needed referring to a mental health professional. It was a very long pregnancy for me.

Maree went into labour spontaneously, laboured well and had a normal birth in hospital. She was cared for and supported in labour by two of my midwifery colleagues, as they felt that her anxious behaviour would be too demanding for one of them to cope with on their own. Maree was very pleased with the care she received and how the labour and birth went. The midwives found caring for her very taxing and described her anxious behaviour as 'extreme' during the labour, but they were pleased overall that she had a positive birth experience. When she did go home from hospital following the birth however, her anxiety was then combined with tiredness and she was almost in crisis. She required intensive visiting and phone calls from me, and support from voluntary agencies we mobilized from the community, for extra help.

I also needed the support and help from my practice partners with her care. We finally arrived at the point where I could discharge her and she verbalized that she was ready. She did calm down eventually and became more rational. I was exhausted by the

relationship with this woman. I went through a whole range of feelings caring for her from deep concern through to extreme frustration. I worked very hard at remaining calm and professional in my interactions with her. I would not call our professional relationship partnership, it was a very hard relationship for me and the only thing that sustained me was the fact that I believe that all women are entitled to midwifery care even the 'difficult' ones.

Caring for clients such as Maree, who are needy and demanding and intrude beyond the boundaries of the professional relationship and into your personal life is something I believe all midwives have to decide how to manage. We meet needy and demanding women from time to time and labelling women 'difficult' is not something I am comfortable with. Erlen and Jones (1999) say that caring for clients who have been labelled 'difficult' is ethically challenging and that, "in applying labels, the nurse does not recognize the particular interests or uniqueness of the patient. Certain patients are deemed to behave more appropriately or have more worth than others" (p. 77). I agree that using labels and stereotyping clients does not help to understand them as individuals and prevents you looking beyond their behaviour as to why they may be behaving in a particular manner.

Having worked in a health care system for the past 30 years as a health professional I am aware that from time to time you encounter clients who do not fit into the system. They often have problems and needs that stretch the systems of health care delivery. We need to be able to provide a service that clients find approachable and effective. Coping with difference of all kinds, be it disability (in this case poor mental health), age, gender, religion, ethnicity, sexual orientation or socio-economic status, is a fundamental skill that needs to underpin our practice as midwives in New Zealand (Nursing Council of New Zealand, 1996). The New Zealand College of Midwives (NZCOM) (2002) says "midwifery care is delivered in a manner that is flexible, creative, empowering and supportive" (p. 7).

Despite working out the boundaries to our relationship together, Maree's anxiety seemed to incapacitate her reason and ability to process information and she did not respond to the boundaries agreed on. I decided that I needed to learn more about maternal mental health so that I could work more effectively and safely with women experiencing anxiety who were behaving in a needy and demanding manner. I find working beyond my knowledge base and skill set stressful. This is possibly why I found

my relationship with Maree so exhausting. Both my hospital-based nursing training (1973-76) and my hospital-based midwifery training (1980) gave little attention to mental health problems. NZCOM (2002) says, "midwifery is holistic by nature: combining an understanding of the social, emotional, cultural, spiritual, psychological and physical ramifications of women's reproductive health experience (p. 3). My midwifery training was only really about the physical with one or two hours at the most devoted to the social, emotional, cultural, spiritual and psychological. My training did not equip me for the realities of midwifery practice.

After learning more about post-traumatic stress disorder I now wonder if that was the source of her anxiety. Her first experience of birth, four years previously, was reported as 'terrible' as it was an induction of labour and a forceps delivery. She became progressively more anxious as the pregnancy went on. Maree also had few friends and no family support. Her husband worked for an international company and they moved frequently with his job. She was highly educated and very skilled at her job in corporate law. Her skills were in demand and she found it hard to turn work down. Maree had very high expectations of herself in her professional role and in her role of being a mother.

Caring for anxious women, in my experience, can be challenging but satisfying. For core midwives it is challenging to care for these women when one also has high client ratios. For the independent LMC midwives it can be a challenge when they have full case loads and the highly anxious women and her family have cell phone and pager access to them 24 hours a day seven days a week.

I feel a sense of urgency about the state of maternal mental health in New Zealand. I also feel concern for the midwives providing midwifery care for women with poor mental heath. I have decided to examine midwives' experiences of working with highly anxious women as a 'beginning place' to look at this problem. I plan to use the principles of feminist enquiry to guide this investigation as it is a method that is grounded in the experiences of women, has a nonexploitative participatory methodology, and emancipatory goals (Gillis & Jackson, 2002, p. 281). This approach is in line with New Zealand midwives' philosophy of care and standards for practice in that we must support and sustain one another professionally, and activities that generate midwifery knowledge do not harm women in any way (NZCOM, 2002).

In keeping with feminist enquiry, I plan to conduct unstructured audiotaped interviews with four independent midwives about their experiences of caring for highly anxious clients. I hope that the themes that are extracted from the data, using Thompson and Barrett's (1997) method of analysing interview transcripts in feminist research, will describe the experiences midwives have when working with highly anxious women.

Mavis Kirkham (1986) says, "the word 'midwife' seems to me to mean in concrete terms exactly what 'feminist' means ideologically: with woman" (p. 35). Feminist researchers recognise that all women are legitimate knowers and that those experiencing difficulty know the most about that experience (Gillis & Jackson, 2002). The women and midwives working in this place are the 'legitimate knowers' of the particular complexities that they face in this space – the midwife-client interface.

The issues that midwives experience while working with highly anxious childbearing women need to be explored. My experience with clients like Maree and the experiences of midwifery friends and colleagues have made me aware of the fact that there are challenges to overcome when working with highly anxious childbearing women.

The next chapter of this thesis will explore the concept of anxiety and it function. It will look at some causes of excessive anxiety and the effect this has on childbearing women and their babies. Chapter three will outline feminist research methodology and my rational for using feminist research principles to guide this research project. Chapter four will describe the research design and chapter five will explain the results. The final chapter, chapter six, will provide a discussion with suggestions for midwifery practice informed by the results of this research and other midwifery research and literature.

CHAPTER TWO: LITERATURE REVIEW

A review of the literature of issues surrounding maternal mental health highlighted many reasons why childbearing women may become anxious and distressed. Axe (2000) says "pregnancy and birth are times of great emotional and spiritual sensitivity, even when both mother and baby are healthy" (p. 628). There is a good deal of research that clearly demonstrates the destructive effect anxiety and distress have on the women, babies and families. The research reports reviewed for this project were varied in their origins and designs. While a small project, such as this two-paper thesis, does not allow for an in-depth critique of each study design addressing the strength, validity and generalizability of the research reviewed, these concepts were kept in mind throughout the literature review. Most of the research was conducted out of New Zealand and most of it was medical. There was a paucity of midwifery research in the field of maternal mental health and little that reflected the recent midwifery or social context of childbearing in New Zealand.

Maternal mental health problems are not a new phenomenon. In 460 BC Hippocrates theorized that suppressed lochia was transported to the brain where it produced agitation, delirium and attacks of mania (Thurtal, 1995, cited in Johnson & Apgar, n.d.). In the 11th century gynaecologist Trotula of Salerno said if the womb is too moist the brain fills with water and the moisture running over to the eyes compels them to involuntarily shed tears (Steiner, 1990, cited in Johnson & Apgar, n.d.).

Studies suggest depression is more common in pregnancy than in the postpartum period. Evans, Heron, Francomb, Oke and Goulding (2001) in a cohort study of depressed mood during and after pregnancy found that the mothers in their sample scored higher for depression during the pregnancy than postnatally. Emotional problems associated with childbirth are sometimes classified as 'the blues', postnatal depression, and puerperal psychosis (Holden, 1990). 'The blues' is a term to describe the emotional fluctuations that 50-70% of women experience in the first few days of motherhood; postnatal depression is a distressing depression affecting up to 20% mothers in the first year after giving birth; and puerperal psychosis is a rare (2-3 per thousand) condition that often has a sudden and dramatic onset with women presenting with symptoms similar to schizophrenia (Holden, 1990). I have often wondered why having children, which is a normal human activity, should make so many women unhappy.

Tisdale (1997) defines anxiety as, "a state of psychological stress" (p. 40). Graham (1997) says, "stress in itself is neither good nor bad, but it is the way in which an individual reacts to a given situation which creates a positive or negative effect" (p. 82). Many prominent psychologists and psychiatrists think we could not live without anxiety and that it is fundamental to what it is to be human (Barlow, 2002). Moderate amounts of stress will increase alertness and performance when, for example faced with examinations, and high levels will enable us to act quickly to escape from dangerous situations (Hunt, Andrews & Sumich, 1995). Anxiety therefore serves as a protective function for the human species. Anxiety motivates humans to seek protection and support from others (Barlow, 2002). It enables us to adapt and plan for the future by avoiding life-threatening situations which are the cause of fear and anxiety (Barlow, 2002).

Looking back over the last 24 years and thinking of those highly anxious childbearing women I have cared for, why they were anxious was specific to them and their personalities and life experiences. Some seemed to have anxious personalities, others had had life experiences that gave them cause for anxiety and distress, and some had both anxious personalities and traumatic life experiences.

GENERALISED ANXIETY DISORDER

Some of my past clients may have had mild or untreated anxiety disorders that made coping with the changes and challenges of having children difficult. Having an anxiety disorder is more than being too anxious about something when others are not. Hunt, Andrews and Sumich (1995) observe that, "individuals with anxiety disorders have specific and recurring fears that they recognise as being irrational or unrealistic and intrusive" (p. vii). They categorized anxiety disorders in the general population as panic disorder, phobias, generalised anxiety disorder and obsessive compulsive disorder.

Hunt, Andrews and Sumich (1995) state that generalised anxiety disorder is one of the most common anxiety disorders with 2-8% of the general population affected. They say sufferers may present with nervousness or restlessness, trembling, sleeping problems, sweating, palpations, frequent urination, muscular tension, fatigue, dizziness, breathlessness and depression. For women who suffer from generalised anxiety disorder the journey of pregnancy, birth and motherhood could be a difficult one considering that it is usually thought to be one of life's major events.

ANXIETY AND PREGNANCY

Tisdale (1997) writes:

> Childbearing is a stressful event, not just in labour, but throughout the pregnancy, and the stress continues through the early parenting process. Individual mothers may react in a wide variety of ways to the same stimulus and much depends on what has happened to that individual prior to the pregnancy. (p. 2)

There has, in recent years, been an increased interest in looking at the effect of anxiety on pregnancy and fetal well-being. Teixeira, Fisk and Glover (1999) found that women who suffered anxiety in their pregnancy have increased uterine artery resistance and significantly abnormal patterns of blood flow through the uterine arteries. Midwifery has known for a long time that stressed mothers produce anxious, small-for-dates, and/or premature babies so this research, as pointed out by Rosser (1999), has given substance to what some midwives have known intuitively. Andersson, Sundstrom-Poromaa, Bixo, Wulff, Bondestam and Astrom (2003), in a Swedish study, looked at 1,795 women during the second trimester of pregnancy and found 14.1% were suffering from some sort of psychiatric disorder but only 5.5% of this diagnosed group were being treated. The women with psychiatric disorders displayed more somatic symptoms and suffered more pronounced fear of childbirth.

Wadhwa, Sandman, Porto, Dunkel-Schetter and Garite (1993) found that prenatal stress factors are significantly associated with infant birth weight and with gestational age at birth; the more stress the mother experienced the greater risk there was of low birth weight and premature birth. Maternal stress in pregnancy has also been associated with poor fetal development and behaviour problems in infants and children. Research conducted by Lou, Hansen, Nordentoft, Pryds, Jensen, Nim and Hemmingsen (1994) suggests that maternal stress in pregnancy is associated with a smaller than average head circumference and less than optimal neonatal neurological functioning.

Gitau, Cammeron, Fisk and Glover (1998) found that fetal concentrations of cortisol are much lower than maternal levels. Mean maternal levels were found to be 547 nmol/L and mean fetal level were found to be 53 nmol/L in paired maternal and fetal venous blood samples. They established that 80-90% of maternal cortisol is prevented from crossing over to the fetus by the placenta but as fetal levels are much lower than maternal levels, if the mother was highly stressed then the 10-20% that does cross over may have a major effect on the fetal cortisol levels. Gitau, Cameron, Fisk and Glover

(1998) suggest that it is the increase in the fetal cortisol levels of stressed women that results in babies with low birthweight and impaired brain development.

A study conducted by Monk, Myers, Sloan, Ellman and Fifer (2003) demonstrated an increase in fetal heart rate during a stress test given to 32 healthy third trimester pregnant women which was related to the mother's overall level of anxiety rather than the mother's own elevated heart rate and blood pressure during the test. Groome, Swiber, Bentz, Holland and Atterbury (1995) found that compared with mothers with low anxiety scores, the fetuses of mothers with high anxiety scores spent significantly more time in quiet sleep and exhibited less fetal movements in active sleep. I read this research report with some interest and started thinking about all those anxious women who are frequently bought into the maternity hospital where I work to be assessed and have electronic fetal monitoring because of decreased fetal movements.

O'Connor, Heron, Goulding, Beveridge and Glover (2002) found "strong and significant links between antenatal anxiety and children's behavioural/emotional problems at age 4 years" (p. 505). They found links between anxiety in late pregnancy with hyperactivity and inattention in boys, and behavioural and emotional problems in boys and girls. These researchers feel there is a direct causal mechanism between antenatal anxiety and the children's behaviour, as the results remained constant even after they controlled for postnatal anxiety and depression, birth weight and prematurity. This study was undertaken as part of the Avon Longitudinal study of Parents and Children in the United Kingdom. O'Connor, Heron, Goulding and Glover (2003), in a further follow up study, found that these behavioural problems persisted in children, whose mothers suffered anxiety in late pregnancy, until as late as six and a half years old.

In a study of 9,529 mother-child dyads conducted by Lesesne, Visser and White (2003) in the United States of America, 6.3% of the sample of school age children were found to have attention-deficit/hyperactivity disorder (ADHD) and that there was a significant association between maternal depression, anxiety and emotional problems and ADHD in school age children. If a mother had mental health problems before her baby was born, raising a child with ADHD would make life more challenging.

This makes for very alarming reading. While pregnant women usually face changes in their lives, relationships and bodies, pregnancy is usually associated with feelings of joy, excitement and anticipation. In my experience highly anxious women are not able

to experience those positive emotions. Protecting pregnant and lactating women from undue stress is a concept that is familiar to most cultures. Oates (2002) observes:

> Since the beginning of time, and across all cultures, childbearing women have been subject to proscriptions and prohibitions of their activities. Many of these might appear to be quaint culture-specific rituals. Nonetheless, vestiges of these proscriptions and prohibitions persist in our own society and are reflected in many of the modern ritual and language of childbirth. Whatever the local meaning and cultural attribution of these behaviours, they are all open to a modern interpretation of protecting the mother and her developing infant from undue emotional stress, infection, malnutrition and a premature return to potentially stressful activities. (p. 479)

Anxiety in pregnancy presents a major public health threat. I do not think that we have taken this threat seriously enough in the past. Prince and Adams (1990) writes:

> The relationship between mother and baby is underway well before the baby is born. The nature and quality of this relationship will not only affect their happiness and psychological well-being, but can also affect the baby's physical growth, social and emotional adjustment and intellectual development. Consideration of the prospective mother therefore needs to extend beyond the obvious physical care which is necessary. (p. 126)

POST-TRAUMATIC STRESS DISORDER AND CHILDBEARING

As midwives, we know that women worry about a multitude of things in their pregnancies and in the early days post delivery. Giving support and information is a major component of our care. In my experience, the emotions of most pregnant women are a mix of positive and negative and, with good communication, support and information, most women are able to keep things in perspective and enjoy the experience. For clients like Maree who become excessively anxious it is more of a challenge. Women can become highly anxious for a variety of reasons such as previous difficult or traumatic pregnancy and birth experiences, as in Maree's case, perinatal loss, fetal abnormality, loss or separation from vital family members.

Over the past 24 years of midwifery practice I have had women share heartbreaking stories of previous traumatic obstetric experiences. While post traumatic-stress disorder (PTSD) has been a condition that has been recognised for sometime, it has not always been associated with childbirth. Humans develop PTSD when they experience an event that is outside the range of normal human experiences, and birth was thought to be a normal human experience (Charles, 1997). Ralph and Alexander (1994) say, "labour, however straightforward, is not 'usual' to women experiencing it; it is a

momentous event by any standards" (p. 29). Niven (1992) cited in Charles (1997) estimated that 7% of women reported classic post-traumatic stress disorder symptoms associated with their child birth experiences. Ralph and Alexander (1993) say that symptoms of post-traumatic stress disorder fall in to three major groups causing flashbacks of the traumatizing event, avoidance of reminders or things associated with the traumatic event and increased emotional arousal. The person often reacts to minor incidences more strongly than normal and suffers excessively from anxiety (Ralph & Alexander, 1993).

I have cared for women in the postnatal period who have been very traumatized by what was judged by the midwife to be a normal labour and birth. I have also cared for other women who have had emergency interventions who feel quite alright and are able to make sense of the experience. It is the mother's perception of the experience that can be traumatising causing PTSD (Crompton, 2002). Traumatic birth experiences are also associated with post natal depression (Creedy, 1999). Creedy (1999) writes that health professionals need to recognize the unique nature of birth for each woman and be aware of their emotional needs to prevent poor psychoscocial outcomes.

Fear of childbirth can lead to requests for elective caesarean section birth. Studies have demonstrated that when women who request elective caesarean section are given extra psychological help and support 50% of the requests were withdrawn (Saisto & Halmesmaki, 2003; Sjogren & Thomassen, 1997). Saisto and Halmesmaki (2003) found that fear of childbirth was associated with fear of pain in general, previous complicated birth, a past history of psychological disorders, life stress, general anxiety, low self-esteem, depression, relationship problems, and lack of social support.

ANXIETY AND PERINATAL LOSS

Women who have had a previous perinatal loss can also be highly anxious in the next pregnancy especially in the third trimester (Hughes, Turton, & Evans, 1999). These researchers found that while the women who had experienced stillbirths in their pregnancy were no more depressed or anxious than the control women at 6 and 26 weeks after their next baby, they did show a trend toward depression after 12 months. Hughes, Turton and Evans (1999) then added 'time since loss' in the analysis and found that it was the women who conceived within 12 months of experiencing a stillborn baby that experienced the psychopathology. Women who conceived after 12 months were no different than the control group for anxiety and depression. These researchers suggest

that women may need to mourn the loss of the stillborn child before beginning another pregnancy, or that women who chose to conceive earlier than 12 months may be more prone to depression and anxiety. Melender and Lauri (1999) looked at fears associated with pregnancy and childbirth and found that the most important fear described by the women was for the baby's health.

Cote-Arsenault, Bidlack and Humm (2001) in a study that looked at the specific emotions and concerns of women who were pregnant after a perinatal loss found that anxiety, nervousness and feeling scared were the most frequent emotions reported.   The women did mention some positive emotions but the researchers said that these were intermingled with "intense concerns and worries" (Cote-Arsenault, Bidlack & Humm, 1998, p. 131). These researchers identified eight themes that described the participants' profound concerns; fear of losing another baby; concerns for the health of the baby; fear that what they would have a negative effect on the baby by doing something wrong; fear of receiving bad news; concern that they were not emotionally stable enough to go through another pregnancy; lack of support from others; worry about the impact on themselves if they experience another loss; as the loss shattered their confidence they were concerned that their worries for their child would never end. I found this research report compelling reading as it provided clear insight into the anxiety of women who have experienced perinatal loss. The responses for the women were comparable regardless of their loss from miscarriage through to neonatal death.

Armstrong and Hutti (1998) found in their study that women who had experienced a previous late pregnancy loss had higher levels of anxiety and decreased prenatal attachment with the child in their current pregnancy. A common theme through out my reading was that the mother-infant relationship both in utero and after birth is a fundamental concept for the success of parenting and child growth and development.

ANXIETY AND MULTIPLE PREGNANCY

Leonard (1998) suggests that, "parents of multiples may be at considerable risk because of the stresses of multiple pregnancy, the extraordinary and unrelenting demands of parenting infants of identical age, and factors pertaining to the parents and infants themselves" (p. 329). My experience of caring for women experiencing multiple pregnancy and parenthood is that it is more stressful and the parents do worry more. This is especially so if the parents have experienced infertility and the pregnancy was achieved with the assistance of modern infertility treatments. These babies are often

much longed for and have arrived after several unsuccessful attempts or miscarriages. Some of the women I have cared for in this situation in the past have been extremely anxious and have required a lot of support and reassurance.

Parents of multiples experience a higher incidence of preterm births, have more infant needs to meet, increased difficulty in giving their infants and other children individual attention, lack support and sleep, and can be socially isolated. These factors contribute to making life very stressful and therefore they are at increased risk of anxiety and depression (Leonard, 1998).

POST NATAL DEPRESSION

I developed an interest in postnatal depression in the past few years. The experience of Ann (pseudonym), a client whose care I was involved with twice, kindled this interest. She came back to see me months after I had discharged her following the birth of her third baby and said that she had just been diagnosed with postnatal depression (PND). She said that two weeks after I discharged her, her life just fell apart.

She became pregnant when her second child was less than a year old. Her first child was just four years old. It was not a planned pregnancy and she was very stressed and worried throughout the pregnancy. At thirty-one weeks her membranes ruptured. She was admitted to hospital and after three days was induced as she was showing signs of infection. She failed to go into labour and the baby was delivered by caesarean section. The baby was in the neonatal unit for five weeks. Ann came home after one week then spent the next month putting her four year old and 16 month old baby into child care and travelling by train and bus to see her every day. The baby was 1900 grams when she came home; she was a slow feeder, and required feeding every three hours. Ann said it was a nightmare.

When I asked her to describe what happed to her I was shocked and ashamed. She described terrifying panic attacks, constant suicidal thoughts, inability to cope with ordinary household chores or care of her children, and emotional outbursts that she said was more like primitive wailing than crying. She said that her partner did not know what to do and she was so ashamed of not coping that she went to extraordinary lengths to hide what was happening from family, friends and the health professionals involved in her care. After six months Ann went to her doctor for help. She did recover when she received treatment and home help but she said it robbed her of that important time

with her baby, stressed her relationship with her older children, and nearly ruined her marriage.

Raphael-Leff (1996) states that, "puerperal women have been found to be 16 times more at risk of developing psychotic illness within the first three months, and have a fivefold risk of neurotic illness during the first year compared with any other period in their lives" (p. 477). Two New Zealand studies found 20% of the participants in their sample groups suffered from PND. Webster, Thompson, Mitchell and Werry (1994), in an Auckland study, found 20% of women (n = 206) had PND at 4 weeks, 13.6% suffered more minor depression and 7.8% had major depression. McGill, Burrows, Holland, Langer and Sweet (1995) in a Christchurch study found 20% of their sample (1,330 women) showed signs of PND, 7% were at the threshold level of depression and 13% were more severely depressed. This represents a lot of very unhappy women and stressed families.

I have cared for many anxious women in the past and have not associated anxiety with depression. My client Ann, with her premature baby, had been anxious throughout the pregnancy. I thought she would 'settle down' once the baby was born. I really did not understand the impact or the consequences of her anxiety. Dion (2002) says "anxiety frequently co-exists with depression yet is often misunderstood, unrecognised and undetected by professionals" (p. 376). Symptoms that can indicate a woman has PND are various anxieties, tearfulness, confusion, inappropriate obsessional thoughts, irritability, fatigue, insomnia, guilt, fear of harming the baby, loss of interest in sexual activity, and personality change (Littlewood & McHugh, 1997). Depressed women can get unusually irritable and or angry with family members. The difficulty for health professionals is that given the nature of pregnancy, birth and motherhood many of these symptoms are associated with 'normal' feelings caused by role and relationship changes, tiredness and sleep deprivation. As a mother of three active, and at times, nocturnal children, I remember feeling some of those feelings some of the time. Greig and Sahar (1997) suggest that:

> With PND, the anxiety can be quite intense and ongoing, almost as if the nervous system is in a state of constant alarm. A woman may feel 'driven', unable to rest or sit down, even while her baby is asleep. She may still be doing housework at two in the morning. (p. 6)

Overseas studies give the rate of PND as 10-15% (Cooper & Murray, 1998; Cox, Holden & Sagovsky, 1987). Overseas studies report the rate for adolescent mothers as high as 26% (Troutman & Cutrona, 1990). However there seems to be a wide variety of suggested rates for adolescents. Deal and Holt (1998) as cited in Clemmens (2000) found that 48% of the 1000 adolescent mothers they surveyed had depressive symptoms.

There are many theories explaining the cause of PND. Cox (1986) brings together several theories under three main headings, psychological, social and biological factors. Cox says "many health professionals have their own favourite ideas" (Cox, 1986, p.33). When reviewing the literature this suggestion of "favourite ideas" is evident and it adds to the confusion.   Webster et al. (1994) found PND was more likely to occur in women who were single, less than 20 years old, unhappy with their relationship with their partner, had a history of previous psychiatric hospitalisation and were Maori. McGill et al. (1995) found factors having the greatest association with PND were: depressive symptoms before and during the pregnancy; serious deterioration in the partner relationship postnatally; decreased energy, confidence, and happiness levels after the pregnancy; moderate or severe premenstrual tension pre-pregnancy; frequent nausea in late pregnancy; low education and low income. Beck (1996b) conducted a meta-analysis of 44 studies looking at the predictors of PND and found prenatal depression, history of previous depression, social support, life stress, childcare stress, maternity blues, marital satisfaction, and prenatal anxiety had significant correlations with PND.

Cooper and Murray (1998) suggest there is little evidence to support a biological cause of PND and, despite extensive research into steroid hormones in women during the postnatal period, no firm evidence has emerged linking these hormones to developing PND. Some researchers believe that a number of women may have a heightened sensitivity to hormonal changes as there have been no consistent hormonal differences found in women with and without PND (Bloch, Schmidt, Danaceau & Murphy, 2000). Bloch et al. (2000) looked at the effect of gonadal steroid levels on women who had already suffered PND by giving women hormones, simulating two hormonal conditions related to pregnancy and birth in non-pregnant women with and without a history of PND. While one would have to question the ethics of this research and wonder how they gained ethical approval to conduct this research, they found that women who had previously had PND developed more symptoms associated with PND than women who had never had PND. Perhaps some women are more sensitive to hormonal changes?

Certainly some of the associated factors found in the McGill et al. (1995) study of moderate or severe premenstrual tension pre-pregnancy, and frequent nausea in late pregnancy, could be biologically based.

Suggested psychological causes of PND are stress from life events and difficulties coping with mothering (Collier, 1996). Raphael-Leff (1996), a practising psychoanalyst and social psychologist, writes:

> Clinical experience reveals that a woman who has unhappy recollections of her own early childhood, or who had lost her mother before being able to establish post-pubertal feminine identification with her, is liable to feel an intense sense of deprivation and sadness postnatally as she relives her own infancy in that of her son or daughter. (p. 484)

Cooper and Murray (1998) suggest that along with obstetric complications the main risk factors are ones based in social adversity and a previous history. Social adversity is discussed in some of the other studies reviewed (Logsdon, Birkimer & Usul, 2000; McGill et al. 1995; Webster et al. 1994; Stein, Cooper, Campbell, Day & Altham, 1989). McGill et al. (1995) found that, "among women with less that 3 years of secondary education, 28% have some degree of depression, whereas among women with trade or professional or job-related training this figure was only 13%" (p. 163). They also found that, "generally, women were less vulnerable to depression as income levels rose" (McGill et al. 1995, p. 163).

Cheryl Tatano Beck, an American Nurse-Midwife and University Professor, has spent many years researching PND. She has undertaken qualitative studies that provide rich descriptions of what it is like for women to suffer PND. Her phenomenological study in 1992 was one of the first qualitative studies done on PND. She identified 11 themes that described the essential structure for the group of women in the study. Beck (1992) says that women do not have to exhibit all the symptoms to be diagnosed as experiencing PND.

Women experience PND in different ways. Nahas, Hillege and Amasheh (1999) conducted a phenomenological study among 45 depressed Middle Eastern women living in Sydney, Australia, and found five themes that illustrated their experience of PND. Chan, Levy, Chung & Lee (2002) also conducted a phenomenological study to explore the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression. In a phenomenological study, Clemmens (2000) explored the experiences of adolescent mothers with depression following the birth of their babies.

Clemmens (2000) writes, "the metaphor of being hit by a nor'easter storm emerged from the participants' descriptions of their experiences and was threaded throughout the description of the themes" (p. 551). While the themes and quotes from the participants in these studies had some similarities there were differences as well, reflecting the different life situations and cultures of the participants. The themes illustrated the intense distress of the participants.

Meighan, Davis, Thomas and Droppleman (1999) in another phenomenological study explored the experiences of fathers whose spouses suffered from PND and found that PND caused major disruption in the participants lives and in their relationships with their partners. They identified the following eight themes -   she becomes an alien, there is a loss of intimacy, he attempts to fix the problem, they have an altered relationship, he makes sacrifices, a real crisis occurs, his world collapses and he experiences loss of control (Meighan, Davis, Thomas & Droppleman, 1999).

 A phenomenological study by Beck investigated the meaning of postpartum depressed mothers' interactions with their infants and older children. This research graphically illustrated the difficulties the participants of this study had in caring for their children while they were depressed. Beck (1996a) writes:

> Participants were overwhelmed by the responsibilities of caring for their children. Guilt, irrational thinking, loss, and anger filled their day-to-day interactions with their children. Mothers went through the motions, acting like robots while caring for their infants. At times, to survive, they erected a wall to separate themselves emotionally from their children and consequently failed to respond to their infants' cues. Detrimental relationships with their older children materialized as mothers were enveloped by postpartum depression. (p. 98)

There is an abundance of research regarding the effect of PND on the cognitive and emotional development of babies and children. Fowles (1998) found depressed mothers had negative feelings about their roles as mothers and especially negative perceptions of their babies. McMahon, Barnett, Kowalenko, Tenant and Don (2001) demonstrated a close association between maternal mood state and unsettled infant behaviour.

High levels of anxiety can interfere with a woman's success in breastfeeding. Henderson, Evans, Straton, Priest and Hagan (2003) found early cessation of breastfeeding was found to be significantly associated with postnatal depression. Delayed onset of lactogenesis is strongly related to the stress experienced by mother and baby in childbirth (Dewey, 2001). Two major risk factors that stand out are long labours

for vaginal births and urgent caesarean sections. Turner, Altemus, Enos, Cooper, and McGuinness (1999) demonstrated that there was a trend towards increased oxytocin release with positive emotion, and a trend to toward reduced oxytocin levels with negative emotion.

The damage to the children of depressed mothers is related to disturbances in the mother-infant interactions (Cooper & Murray, 1998). Beck (1995b), in a meta-analysis of 19 studies, found that PND had a moderate to large effect on maternal-infant interaction. PND has been shown to adversely effect the cognitive and emotional development of infants (Beck, 1998). Male children and socioeconomically disadvantaged groups are the most susceptible to the damage of PND (Cooper & Murray, 1998). Gross, Conrad, Fogg, Willis and Garvey (1995) in a longitudinal study, looked at the relationship between PND and pre-school children's mental health. They found that PND was significantly related to lower social competence and more behaviour problems in the children, especially boys. Gross et al. (1995) suggested "boys' behaviours may be particularly aversive for depressed mothers, increasing the likelihood that these mothers will respond to and reinforce their sons' difficult behaviours" (p. 96).

With a possible rate of 20% for PND in New Zealand mothers and our rising obstetric intervention rates, which are potentially traumatising for women, the situation looks serious for New Zealand mothers' mental health. Poor maternal mental health has serious implications for the health and development of children and puts a severe strain on family and partner relationships. After conducting a literature search and reflecting on my professional and personal experience of pregnancy and motherhood, I feel that women in general become anxious not because there is something wrong with them, rather there is something very wrong with the way childbearing women are treated by our society.

Broom (1994) as cited in Page (2000, p. 213) suggests that researchers ask the question " 'what kinds of society, community and social arrangements protect and support mothers and babies? *rather than* 'What kind of women are at risk of PND?' ". Enkin, Keirse and Chalmers (1989) said, "because many of the social factors leading to postpartum unhappiness are rooted in society's expectations of new mothers, the solutions lie mainly in social change" (p. 14).

A study by Kit, Janet and Jegasothy (1997) found the rate of PND in their sample of women in Malaysia to be as low as 3.9% and suggested that this may be because the majority of Malaysian women still observed the traditional postnatal beliefs and practices. These usually include special diet to restore strength and health, not being left alone, and given help with childcare and domestic duties by family members for a month.

Nicolson (1998) says that motherhood "is a role that receives decreasing support from government sources in western industrial societies, although these are the very communities where traditional support from extended family networks may no longer be relied upon" (p. 1). Ussher (1991) clearly feels that maternal mental health problems are caused by mothering in a patriarchal society. She believes that our patriarchal society prescribes women's roles and life routes and, if women are unhappy about their lot, labelling them 'mad' silences them. She says that women who are perceived as showing symptoms of madness are not mad; rather they are angry and outraged at having to conform to the stereotypes of feminity.

CONCLUSION

It is expected that midwives care for childbearing women in a holistic manner, that is the social, emotional, cultural, spiritual, psychological as well as the physical (NZCOM, 2002). Women with high levels of anxiety, like Maree, who do not have a supportive network in their lives and have life experiences or personalities that make them highly anxious often look to their midwife for the support they need.

While anxiety in human beings is normal for human survival, excessive and prolonged anxiety in childbearing women is a serious public health concern. The research suggests that the root of maternal mental illness lies in social adversity and a history of mental health problems. I have observed LMC and core midwives struggling to support women with high levels of anxiety. It is almost as if midwives have to plug the gap between what support childbearing women need and what our society provides.

CHAPTER THREE: METHODOLOGY

I chose the feminist approach to research because, as a midwife, I believe the research process should reflect our professional philosophy and values of practice. Gillis and Jackson (2002) say "the purpose of feminist research is to create social change that will benefit women" (p.282). I also chose this method because I do believe that our society and its values and structures do not support childbearing women. Barnes (1999) suggests:

> Feminist theoretical framework is appropriate to the study of childbearing and midwifery as feminism seeks to address and overcome the oppression of women and in so doing provides an appropriate framework within which to examine issues and practices which influence the lives and experience of women. (p. 6)

My choice of career was influenced by my upbringing and family socialization. My mother was a midwife. I was fortunate to be part of a large extended family and the eldest of seven children. As a young girl I recognized that women were the silent workers in society and, while they worked hard at a role that I considered vital to the success of society, their rights or needs were not considered important. I saw midwifery as a career that would enable me to be helpful to mothers. I have not in the past labelled myself as a feminist. On reflection, as a women in her late 40's, mother of three children and with 24 years of midwifery practice behind me, I feel comfortable with the feminist literature I have reviewed in the course of my studies so have come to the conclusion I am a feminist after all.

Stanley and Wise (1983) write, "what is essential to 'being feminist' is the possession of 'feminist consciousness' . . . . we see feminist consciousness as rooted in the concrete, practical and everyday experiences of being, and being treated as, *a woman*" (p. 18). They feel that 'feminist consciousness' is an understanding of what it is like to be a woman in a sexist society. While I may not have been involved in the past with feminist activities or campaigns, I think that I am more of an everyday feminist in that I live in New Zealand society as a woman and work as a midwife. I know the issues that women deal with every day. As Stanley and Wise (1983) say, I feel I am 'doing feminism' in every day life.

Guilliland and Pairman (1995) say "as a profession made up predominantly of women and with a focus on women and women's experiences [of childbirth], midwifery recognises and values women's different views of the world and unique ways of

knowing" (p. 28). I feel that it is appropriate therefore to look at midwives' experiences of caring for highly anxious childbearing women by using a feminist approach.

FEMINISMS

Defining feminism is not straightforward. It would appear that there are many schools of feminist thought. Guilliland and Pairman (1995) say:

> In keeping with the belief that all women are valued and that each woman's experience is unique, midwifery recognises the contribution of all schools of feminist thought, each reflecting a different focus for understanding modern women's 'place in the sun'. (p.28)

Putnam Tong (1998) suggests ten types of feminism – liberal, Marxist, radical, psychoanalytic, gender feminism, existentialist, post-modern, multicultural, global and ecofeminism.   She believes that labels remain useful as they:

> Signal to the broader public that feminism is not a monolithic ideology, that all feminists do not think alike, and that, like all other time-honored modes of thinking, feminist thought has a past as well as a present and a future.
>
> (Putnam Tong, 1998, p. 1)

Some feminists allege that the mere act of categorising is a "maleness" act (Crotty, 1998). Gillis and Jackson (2002) suggest that more recently "these distinctions have become blurred" (p. 281). Brayton (1997) believes that "at a basic level feminism recognizes the organizing of the social world by gender" (Definitions section, ¶ 1). Letherby (2003) writes, "variety is an essential ingredient and strength of feminist research" (p. 2). Franks (2002) suggests the way forward, "is in recognizing the existence of a multiplicity of standpoints and the ways in which they not only divide us but also the ways in which they can facilitate issue-based coalition" (Located Feminisms section, ¶ 6). Stanley and Wise (1983) argue against set typologies of feminism because they feel complexities, ambiguities and contradictions are ignored, and static and fixed ideas do not take into account the lived experience of feminism that they feel is more fluid and dynamic allowing for people to change.

Gillis and Jackson (2002) say that one should use the term 'feminisms' instead of 'feminism'. They point out that all feminisms generally adhere to the same basic principles in that they all value women and their experiences, ideas and needs; they view phenomena from a woman's perspective; they recognise the existence of the

conditions that oppress women and they all strive to change those conditions through criticism and political action (Gillis & Jackson, 2002).

FEMINIST EPISTEMOLOGY

Stanley and Wise (1993) say, "an 'epistemology' is a frame work or theory for specifying the constitution and generation of knowledge about the social world; that is, it concerns how to understand the nature of 'reality' (p. 188).

Letherby (2003) says, "many feminist writers have argued that knowledge, reason and science have been 'man-made' (p. 20). Dubois (1983) cited in Westmarland (2001) says that 'universal' knowledge is man-made and therefore fundamentally flawed. In western societies, "men have used their positions of power to define issues, structure language and develop theory" (Letherby, 2003, p. 20). Throughout history women were thought to be incapable of intellectual thought and so were consequently unable to generate scientific knowledge. Plato (427-347BC) believed that women developed from the souls of men who lacked reason (Loyd, 1984, cited in Westmarland, 2001).

Harding (1986) writes, "the idea that there might be innate differences between the intellectual powers of men and women has been banded about for hundreds, if not thousands, of years" (p. 11). She includes a collection of quotes in her book that she felt was the fairest way to illustrate the general attitude of men in the past to women's ability to participate in science and generate knowledge. The following two quotes I found intriguing and illustrate the attitude of the day in 18th and 19th century. "Women are cast in too soft a mould, are made of too fine, too delicate a composure to endure the severity of study, the drudgery of contemplation, the fatigue of profound speculation" (The British Apollo, 1708, cited in Harding, 1986, p. 11). The Editor of the 'British Apollo' would be incredulous if he could have caught a glimpse into a university in the 21st century.

Another quote from Harding's book was: "nature herself prescribed to the woman her function as mother and housewife and that laws of nature cannot be ignored…without grave damage, which…would especially manifest itself in the following generation" (Max Planck, about 1897, cited in Harding, 1986). I think that maybe Mr Planck would be turning in his grave if he knew that women are actually able to be partners in successful relationships, mothers, engaged in professional employment, study and research all at the same time.

Crotty (1998) suggests that women do not 'know' in a different way to men but rather women "express concerns, raise issues and gain insights that are not generally expressed, raised or gained by male epistemologists" (p. 174). Gilligan (1993) suggests that women speak with a 'different voice' and that men and women have different ways of perceiving the world. Gillis and Jackson (2002) write that "feminist philosophers believe all women are legitimate knowers and that those experiencing particular complexities are the most knowledgeable about that experience" (p. 283).

New Zealand midwives aim to provide women centred care, recognize and value different ways of knowing, and recognise that women need to control their pregnancy, labour and birth (NZCOM, 2002). Midwives are in accord with feminist philosophers and recognise women as knowers of women's issues especially pregnancy, birth and motherhood. Guilliland and Pairman, (1995) say "midwives are concerned with assisting women in the emergence of consciousness and their different ways of knowing in order for them to speak with their own voices" (p. 29). The feminist approach to research will assist with building knowledge generated by women, for women, and about women, with the aim of improving midwifery practice and the lives of women in the child bearing years.

ORIGINS OF FEMINIST RESEARCH

Oakley (1992) writes that, "there have been two major sources of challenge to the orthodox model of knowledge since the 1950's: one from within the social sciences and one that emerged from the political movement of the liberation of women" (p. 338). McCormack (1989) states:

> Feminist research began as a response to the feminist movement which had a strong will and deeply felt aspirations but little ideology and evidential knowledge to back up its claims . . . . it was intended to persuade and mobilize, to raise the consciousness of women and to create a climate of opinion which would make the achievement of feminist goals that much easier. (p. 17)

Westmarland (2001) writes: "second wave feminism developed in the 1960's and questioned not only *how* knowledge is produced, but also *who* produces it and how it is *used*" (Introduction section, ¶ 3). Letherby (2003) writes that, "historically, women have felt discrepancies between how they felt and experienced the world and the 'official definition' of their identity (p. 42).

Feminist researchers recognise that patriarchy pervades society and leads to the domination of women and children by men and this domination is fostered and maintained by sexist social ideologies (Gillis & Jackson, 2002). For some feminist researchers, this awareness of oppression is little more than a perception that the playing field is not level, but for others the inequity is felt with more intensity and severity (Crotty, 1998). McCormack (1989) writes that the goals of the feminist movement are "equality and liberation, equity and self-determination . . . . indeed, feminism could be conceived of as part of a larger worldwide movement for justice and autonomy" (p. 18). Feminist research has developed to facilitate the attainment of these goals.

FEATURES OF FEMINIST RESEARCH

What makes feminist research feminist is that feminist beliefs and concerns underpin the research process (Brayton, 1997). Brayton (1997) writes:

> Methodologically, feminist research differs from traditional research for three reasons. It actively seeks to remove the power imbalance between research and subject; it is be (*sic*) politically motivated and has a major role in changing social inequality; and it begins with the standpoints and experiences of women.
>
> (Defining feminist research section, ¶ 1)

NONEXPLOITATIVE RESEARCH RELATIONSHIPS

Feminist researchers strive for relationships based on equality within the research team and with the participants (Gillis & Jackson, 2002). The researched are referred to as participants or co-researchers and not subjects (Reinharz, 1992). The researcher is careful to develop nonexploitative relations with the participants (Reinharz, 1992). Feminist research encourages rapport building between participants and the researcher as a way of treating the participants in a nonexploitative manner, thereby validating the researcher as a feminist and a human being (Reinharz, 1992). Rapport building also symbolises the researcher's, "sisterhood, her interviewing skill, and her ethical standing" (Reinharz, 1992, p. 265). Gilligan (1993) says, "to have a voice is to be human. To have something to say is to be a person. But speaking depends on listening and being heard; it is an intensely relational act" (p. xvi). In answer to the critics from mainstream research Hall and Stevens (1991) argue that evidence of rapport building addresses validity as it increases the accuracy of how well the participants' reality is entered.

Reinharz (1992) highlights the fact that this involvement in the participant's lives is "full of ambiguity and controversy" (p. 266) and there seems to be a range or degree of involvement in feminist projects from no involvement to "deep, mutually satisfying reciprocal relationships" (p. 266). She suggests that researchers remember not to only focus on the latter. Reinharz (1992) points out barriers to rapport building such as class, educational, and even ideological differences. She says, "there are times when feminist researchers will study people for whom they have little respect" (Reinharz, 1992, p. 267). She suggests that it is dangerous to *require* rapport in all feminist research and that rapport should be considered a fortunate outcome (Reinharz, 1992). She believes that nonexploitative relations can be also based on "respect, shared information, openness and clarity of communication" (Reinharz, 1992, p. 267).

Feminist researchers pay particular attention when reporting findings of research projects. They ensure that they use non-sexist language and write in a user friendly manner making reports accessible to all, not just intellectuals (Gillis & Jackson, 2002). Feminist researchers often find it difficult to publish the findings of their research because of 'gatekeepers' in the academic community, i.e. the editors, referees or reviewers of journals and conference papers (Brayton, 1997). Feminists sometimes find that academia stifles originality and for some academics the word 'feminist' presents a frightening challenge, however it is important that feminists publish in mainstream channels so that their influence is extended beyond the already converted (Letherby, 2003).

THE ROLE OF SUBJECTIVITY

Unlike traditional research where the process is "formal, rigorous and precise" (Gillis & Jackson, 2002, p. 6), where impartiality is valued and personal knowledge and attitudes are often bracketed, feminist research allows a different relationship between researcher and participants. Franks (2002) argues that, "feminist methodology in general has treated the goal of objectivity in research as an unobtainable phantasm" (Objectivity section, ¶ 1). Letherby (2003) writes: "feminists insist that it is not possible for researchers to be completely detached from their work: emotional involvement cannot be controlled by mere effort of will and this subjective element in research should be acknowledged, even welcomed" (p. 68).

Reinharz (1992) writes that, "feminist researchers generally consider personal experiences to be a valuable asset for feminist research to the extent that this is *not* the case in mainstream research, utilizing the researcher's personal experience is a distinguishing feature of feminist research" (p. 258). Stanley and Wise (1983) state that:

> We feel that it is inevitable that the researcher's own experiences and consciousness will be involved in the research process as much as they are in life, and we shall argue that all research must be concerned with the experiences and consciousness of the researcher as an integral part of the research process. (p. 48)

It was my experiences with clients such as Maree and Ann that influenced my decision to carry out this research. I have an interest in the subject; it concerns me. Feminist researchers incorporate their knowledge and experiences into the data, share their experiences with the participants (Gillis & Jackson, 2002) and in some cases "give direct assistance to the women they study" (Reinharz, 1992, p. 264). Letherby (2003) states that "feminist research *is* feminist theory in action (p. 62). Gillis and Jackson (2002) suggest that:

> The researcher needs to be reflexive about her views so that she can uncover deep-seated views on issues related to the research and provide a full account of her views, thinking, and conduct. This is necessary so that readers of the research report are aware of how the researcher's values, assumptions, and motivations may have influenced the frame-work, literature review, design, sampling, data collection, and interpretation of findings. (p. 285)

Webb (1993) believes that this process adds to the significance and truthfulness of the results. Hall and Stevens (1991) argue that in feminist enquiry "the objectivistic stance and the anonymous, invisible voice of authority are avoided in favour of a strongly reflexive approach to inquiry . . . . feminist perspectives stand in stark contrast to the philosophical underpinnings of the positivist-empiricist paradigm" (p. 18). Hall and Stevens (1991) state that: "verifying the adequacy of research findings remains an issue for feminist researchers" (p. 16). They suggest:

> Feminist research is best evaluated by standards of rigor that reflect the adequacy of the whole process of inquiry, relative to the purposes of the study, rather than by standards that focus only on the accuracy and reliability of measurements within the study. (Hall & Stevens, 1991, p. 20)

Feminist researchers reject the objective manner of academic writing and prefer to write in the first person. This style of writing is not without its dangers, as while writing as 'I'

the researcher takes responsibility for what is written, the researcher can be intellectually discredited by those in authority in the academic world (Letherby, 2003). Letherby (2003) writes that, "in research that sometimes raises emotional as well as intellectual issues, as feminist research often does, the use of 'I' may lead to accusations of 'un-academic' indulgence" (p. 7). Reinharz (1992) suggests that in feminist research the researcher addresses the reader directly desiring to forge a connection through herself between the reader and the people researched and in the hope that the reader is helped to free herself from patriarchy.

RESEARCH METHODS

While reviewing the literature on feminist research methods it becomes clear that there is a huge variety of opinions as to the methods of choice. Hall and Stevens (1991) posit that, "feminist research, in general, is distinguished by certain features, even though it may utilize a variety of methods" (p. 17). Gillis and Jackson (2002) write that this, "variety of perspectives and a multiplicity of methods, including both qualitative and quantitative methods . . . . reflect the complexity of women's lives that are sufficiently complex and diverse to require multiple perspectives" (p. 282).

Some feminist researchers support qualitative methods, some quantitative methods and some advocate combining the two (Reinharz, 1992). Some feminist scholars feel very strongly that quantitative methods are inadequate for feminist research. For example Graham (1993) as cited in Westmarland (2001) believes that statistical surveys treat the participants as equals which does not reflect the patriarchal society in which the data are collected. However, Reinharz (1992) feels that surveys can be useful when looking at the prevalence and distribution of particular problems in society and other feminist researchers feel that sensitively worded surveys can provide useful background information. Oakley (2000) feels that "the paradigm war has set us against one another in ways that have been unproductive in answering some of the most urgent social question facing us today" (p. 323). I agree with Oakley (2000) as she believes that we should forget the gendering of research methods and:

> Abandon sterile word games and concentrate in the business in hand, which is how to bridge the gap between ourselves and others, and to ensure that those who intervene in other people's lives do so with the most benefit and the least harm. (p. 3)

Gillis and Jackson (2002) acknowledge that while feminist researchers use a variety of methods they say, "most emphasis seems to be on qualitative methods, particularly using in-depth interviews" (p. 281). Most of the literature I read referred to the work of sociologist and feminist Ann Oakley. Letherby (2003) said that she was the first to advocate the in-depth interview as the best way to find out about people's lives. Letherby (2003) writes:

> This approach is not only viewed by many as politically correct and 'morally responsible' but is clearly very relevant in terms of the development of an approach which is grounded in the experience of women. Letting women speak for themselves and (in part at least) set the research agenda is likely to produce work which can be used by women to challenge stereotypes, oppression and exploitation. (p. 84-45)

Letherby (2003) states that Oakley's work in the early 1980's, with its 'participatory model', was very influential and since then feminist researchers who wish to break down research hierarchies begin with reference to her work.

Not all feminist researchers share Oakley's views. Letherby (2003) outlines common critiques of the 'participatory model' and in-depth interviews as having the potential to be exploitative by nature and that not all women want to share their experiences nor would it be of benefit for them to do so. Finch (1984) cited in Letherby (2003) points out that a friendly researcher may find vulnerable people who may reveal very confidential information about themselves which raises ethical concerns.

Feminist researchers embrace diversity in sample selection, reflecting the diversity of women's lives, and attempt to include women of diverse social class, race, ethnic groups and cultures (Gillis & Jackson, 2002). This is in direct contrast to mainstream research. Hall and Stevens (1991) write, "much of traditional empiricist research reduces human nature to an array of isolated variables examined in a narrow, decontextualized format. Frequently the search for universal social processes forsakes attention to the conditions that envelop phenomena" (p. 23). In answer to mainstream critics Hall and Steven (1991) suggest that, "rigor in feminist inquiry includes the degree to which research reflects the complexity of reality" (p. 23).

The general theme running through the literature was that the choice of method depended on the question asked, but what was most important was that the research was based on the common principles, goals and ideologies of feminism. Crotty (1998) writes:

To all outward appearances, feminist researchers may share methodologies and methods with researchers of other stripes; yet feminist vision, feminist values and feminist spirit transform these common methodologies and methods and set them apart. Far more than ways of gathering and analysing 'data', methodologies and methods become channels and instruments of women's historical mission to free themselves from bondage, from the limiting of human possibility through culturally imposed stereotypes, life-styles, roles and relationships. (p. 182)

RELEVANCE TO MIDWIFERY

While, as Reinharz (1992) asserts, "feminists are creatively stretching the boundaries of what constitutes research (p. 268), Barnes (1999) writes, "for midwifery, this approach provides a framework to examine the developing women-centred modes of midwifery practice and underpinning philosophies (p.9). Hall & Stevens (1991) write, "the history of oppression, invisibility, and objectification of women underscores the need for a more relevant, just, and complete framework for evaluating research about and for women" (p. 27).

In my judgement, feminist ideology and research frameworks assist midwives of my generation to separate their practice from the patriarchal medical model of practice that underpinned our initial training (24 years ago) to the women-centred partnership model of midwifery care today. Webb (1993) writes, "feminist research is located within a post-positivist paradigm" (p. 416). Katz Rothman (1989) writes, "the very word *midwife* means *with the woman*. That is more than a physical location: it is an ideological and political stance" (p. 170). Davies (1998) asserts that for midwives "our task is to refuse to occupy the places that silence and oppress us, to expose them as such and make our impact on the future a positive one for women" (p. 14).

As midwifery strives to build the knowledge on which to base our women-centred practice, I think that the research process should reflect the professional philosophy and values of our practice. The feminist approach to research, which is grounded in the experiences of women, with its nonexploitative participatory methodology and emancipatory goals, has much to offer midwifery and women. While the approach may present a challenge to the mainstream research community, I feel that midwives do have an emancipatory role in the care of childbearing women if we are to improve the lives of midwives and women.

Jebali (1993) writes, "to bear and rear children is often a fundamental part of a woman's life, yet to be a mother is to occupy a low status position in our society" (p. 203). What

you 'do' professionally and how much you earn sometimes seems to equate to your perceived worth to society.

So much of the research surrounding maternal mental health is medical and views poor maternal mental health as a 'woman's illness'. I have often wondered what is it about our society that makes 1 in 5 women feel so miserable. I do think that maybe the answer does not lie with women but rather lies in the social structure of our patriarchal society. Anne Oakley (n.d.), a psychotherapist from Canada says:

> If women aren't healthy then society is not going to run very well. We're caregivers, mothers, workers, and daughters, people who add a great deal to society and who society depends upon a great deal. If we're not healthy, society's not going to be very healthy. (Why is it important section, ¶ 1)

CONCLUSION

The feminist approach to research fits with my personal and professional midwifery philosophy. It will give the participating midwives a voice to share the issues they face and experience while working with highly anxious childbearing women, and it will also enable me to incorporate my experiences of working with highly anxious childbearing women. I hope that this research will generate discussion that will lead to improvements that will benefit midwives and the mothers in their care.

CHAPTER FOUR: RESEARCH DESIGN

In order to gain more understanding of midwives' experiences of caring for highly anxious childbearing women I chose a qualitative approach guided by the principles of feminist research. Kvale (1996) claims:

> Qualitative methods are not merely some new, soft technology added to the existing hard-core quantitative arsenal of the social sciences. Rather, the mode of understanding implied by qualitative research involves alternative conceptions of social knowledge, of meaning, reality, and truth in social science research. (p. 10)

As midwifery practice is both science and art by nature, qualitative research combines both these components and improves our understanding of health-related issues (Marcus & Liehr, 1998). Gillis and Jackson (2002) write, "the goal of qualitative approaches is understanding rather than prediction and they emphasize the subjective dimension of human experience" (p178).

As discussed in the previous chapter the overall principles of feminist research are: valuing women's experiences; examining phenomena from women's perspectives; recognition that woman are oppressed and aiming to improve women's lives (Gillis & Jackson, 2002). Denzin and Lincoln (2000) write, "qualitative researchers deploy a wide range of interconnected interpretive practices, hoping always to get a better understanding of the subject matter at hand (p. 3). I chose to collect the data for this investigation by face-to-face, audiotape recorded, unstructured interview as I wanted to gain understanding of the issues that midwives experience while working with highly anxious childbearing women. Fontana and Frey (2000) say that "interviewing is one of the most common and powerful ways in which we try to understand our fellow human beings (p. 645). Kvale (1996) feels that the qualitative research interview is "a construction site for knowledge" (p. 14).

When I reflect back on my career of both working in hospitals as a core midwife, and in the community, it was working with highly anxious clients such as Maree in the community as a self employed midwife, available to her twenty four hours a day, that was the most challenging experience. While caring for highly anxious women as a core midwife in the hospital setting, with other women to care for and ward duties to carry out, presents its own set of challenges, I decided because of the scope of this two paper thesis to focus my investigation on the experiences of independent Lead Maternity Care (LMC) midwives working in the community.

ETHICAL CONCERNS

Gillis and Jackson (2002) asserts that ethics is "concerned with the goodness and badness of human actions or with the principles of what is right and wrong in conduct" (p. 323). Health professionals hope to bring about improvements in health status through ethical actions in both the field of research and in clinical practice (Gillis & Jackson, 2002).

I have two reasons for conducting this research. One reason is the gaining of an academic qualification, and the other stems from my interest in maternal mental health issues. I would like to add to my own and other midwives' understanding of the issues that surround the care of highly anxious childbearing women with a view to supporting midwives, improving practice, and the mental health status of childbearing women. Traditionally, the main ethical concerns when interviewing human beings for research are issues of informed consent, right to privacy and protection from harm (Fontana & Frey, 2000).

INFORMED CONSENT

The midwives were recruited by the snowball method. When they showed an interest I phoned them, introduced myself, and gave them a verbal explanation of the purpose of the research, the process and level of involvement and shared the intention to publish the thesis so that they could make an informed decision to participate. I then followed up by posting the participants an information sheet and a consent form. They signed the consent form at the interview before it commenced. I was surprised by how willing they were to be interviewed, given that three of the midwives did not know me, and that the interview was going to be audiotaped. I made it clear in the information sheet that they could withdraw at any time, without prejudice, before the data analysis was started. None of them did.

PRIVACY

To meet the participants' need for privacy I did not include any midwives with whom I worked in my district or midwives with whom I usually associate. The participant's identities have been anonymised and the names used in this thesis are pseudonyms. I was also aware that by interviewing midwives out of the district where I work there was less likelihood that I would hear stories of clients or other health professionals that I

knew; and this offered the participants, their clients, and allied maternity health professionals and providers some measure of privacy as well. As I worked with the transcripts I removed all the names of people and maternity services before they were returned to the participants for feedback. The data were kept in a secure place in my home and the tapes and the transcripts were only available to me, the transcriber and my supervisor. All information on my computer was held in files with a password to ensure confidentiality.

I also undertook to not discuss with anyone the identities of the participants or where they lived or worked. As my transcribing was being done professionally I required the transcriber to sign a confidentiality agreement before she commenced. All of the participants were made aware that this thesis would be placed in the university library and that they would be given the opportunity to review the thesis before it was finally printed. All the participants said that they would be happy to wait for the final printed version.

PROTECTION FROM HARM

I was very conscious that there is potential for harm when interviewing participants and asking them to share their practice experiences. My first consideration was time. I did not want to waste the midwives' time. I interviewed them at a time and place convenient for them. I asked them for an hour of their time and while I was happy to spend more time with them if they wanted to talk for longer, I kept the formal part of the interview with the audiotape recorder going for no more than an hour.

I provided food when the interview occurred over a meal or break time. I did not want the midwives to miss a meal because of the interview as I was aware that they could be called out at any time. The midwives all chose to be interviewed in their own homes either at the beginning of their day or at the end of their visits. I was happy to do this so that they did not have to drive, find an unknown address, secure a car park or talk to a stranger (me) in a strange place. I did not want the interview to be a source of stress for the midwives. Letherby (2003) argues that, "doing research in a respondent's own space will usually make them feel more in control" (p. 108). I was aware that I was an invited guest in their homes and I was conscious of having been invited into their personal and private space.

As with any interview situation I was aware of the potential for participants to become upset or distressed. In my experience, working with anxious women like Maree can be very stressful, and I remember feeling very frustrated at times.   I was happy to terminate the interview at any stage and was willing to do a follow up discussion myself or arrange for a supervision session with a senior midwife, or facilitate another form of support or counselling that the midwife thought would be effective or appropriate. Feminist enquiry is feminist theory in action (Letherby, 2003) and so to offer assistance to participants is expected (Reinharz, 1992). This situation did not arise. As far as I could tell, apart from the usual shyness and awkwardness of starting a conversation with a complete stranger, especially one who arrived with an audiotape recorder, once we started talking about our experience of caring for anxious childbearing women the conversation flowed, the audiotape recorder was forgotten, and a comfortable rapport was established quite quickly.

Another factor to consider when endeavouring to protect the participants from harm was that I did not want to offend the participants with my own opinions, attitudes or comments. Letherby (2003) writes, "researchers, too, may feel strong emotions in the field" (p. 111). Because I was interviewing midwives whom I did not know, I had to be prepared to deal professionally and sensitively with attitudes that annoyed me, or with midwifery practices that I did not think met acceptable standards of practice. This situation did not occur from my perspective. After listening and reflecting on all four of the midwives' interviews about their experiences I was full of respect for these women, and the interviews were a positive experience for me. The midwives did express at the end of the interviews, as I was leaving, that they thought it was helpful to talk about this particular aspect of practice.

There were other ethical principles that are discussed in the Victoria University of Wellington's Human Ethics Guidelines for research which I considered when I was planning this research project. They were limitation of deception, social and cultural sensitivity, and the merit of the research to midwives and women (Victoria University of Wellington, 2001). I kept these in mind when I was writing my information sheet and the consent form, so that the midwives were fully informed and the research process was transparent.

I did not ask the midwives which ethnic or cultural group they identified with, but two of the midwives identified themselves as English in the interviews, and one did talk

about the different social and cultural aspects of her family upbringing, society and midwifery training and work in England, and compared these to her life and work here in New Zealand. As midwives, acknowledging and respecting different ways of knowing and practicing in a culturally safe manner, is an expected standard of practice here in New Zealand (NZCOM, 2002). Watson (1988) suggests, "we have to treat ourself with gentleness and dignity before we can respect and care for others with gentleness and dignity" (p. 33). I think that this is applicable to midwives both individually and collectively.

There is merit for midwives and women in this research project. I feel a sense of urgency about the poor state of maternal mental health in New Zealand. As the research shows, anxiety and childbearing are associated with considerable risk to the woman, her child and her family. I have chosen to look at midwives' experiences of working with anxious and distress women as a 'beginning place' to explore this problem. Midwives are well placed to be part of improving our clients' mental health. We are there with them for months. The place where midwifery takes place is at the midwife-client interface, where care is given and received. The women and midwives working in this place are the 'legitimate knowers' of the particular complexities that they face in this space.

Page (2000) states that, "the essence of midwifery is the assistance of women around childbirth in a way that recognizes that the physical, emotional and spiritual aspects of pregnancy and birth are equally important" (p. 1). We need to know the issues that face midwives as they work with women who are highly anxious and distressed. I know from my own experience, and the anecdotal accounts from other midwives, that caring for these women presents challenges. While the scope of this enquiry is small, and the results will be very specific to those midwives who participated, I hope the results may generate discussion that could lead to further research and changes in practice, that are aimed at making the world a better place for midwives, women and their families.

TREATY OF WAITANGI IMPLICATIONS

As midwives registered to practice in New Zealand we are bound by the New Zealand College of Midwives (2002) to practice within the principles of the Treaty of Waitangi – protection, partnership and participation. These principles also extend to midwifery research. While my research project is not specifically aimed at Maori midwives or

women, Maori woman are the Tangata Whenua in New Zealand and are still bearing the burden of our colonial history.

Research has shown that Maori women as a group are more prone to mental illness during pregnancy and in the postnatal period. Webster et al. (1994) found PND was more likely to occur in women who were single, less than 20 years old, unhappy with their relationship with their partner, had a history of previous psychiatric hospitalisation and were Maori, stating that "in our current New Zealand social and political climate Maori mothers are more likely to be economically and educationally disadvantaged, and have access to poorer housing" (p. 48). The Health Research Council of New Zealand, in their Maori Health Research Themes, identifies stress as a cause of poor health for Maori women as a result of the difficulties Maori women face caring for others while living on a very low income (Health Research Council of New Zealand, 1998).

 Any health research that involves Maori needs to benefit the health of Maori (Durie, 1996). The aim of feminist research which is grounded in the experiences of women, with its nonexploitative participatory methodology and emancipatory goals is therefore closely aligned with the principles associated with Treaty of Waitangi of protection, partnership and participation. As researchers we need to use these principles to guide our actions throughout the research process so that our enquiry generates health information that benefits our colleagues and clients without causing harm or offence. If this small research project contributes, in any way, to midwives' understanding of the issues experienced while working with women with mental health problems and benefits midwives' and childbearing women, including Maori women, it will have been useful.

RECRUITMENT OF PARTICIPANTS

To recruit participants for this enquiry I used the snowball technique or chain referral. This is done by finding one participant who fits the participant criteria and asking them if they could recommend another person who fits the criteria to participate until the number of participants needed is reached (Cluett & Bluff, 2000).

Criteria for participant inclusion was that they had to be independent LMC midwives who did not live in my geographical area. I did not want to interview midwives who worked in my geographical area as there was a chance that the participants or their clients could be identified. After I had ethical approval of the Standing Committee of

the Human Ethics Committee of Victoria University of Wellington (see Appendix 1) to proceed with the research, I contacted an ex-colleague who lived out of the district and asked her if she would be interested in participating and starting the ball rolling with recruiting other midwives.

This proved to be a successful method to recruit the first three participants, but it was slow because the midwives were busy people with unpredictable working hours. To speed up the process I recruited the fourth out of the district midwife through another colleague. I was surprised at how willing the midwives were to participate in my research. I wondered if this was because the subject was something they wanted to talk about. Conducting and collaborating in research is part of midwifery standards for practice (NZCOM, 2002) and I know from experience that midwives often share practice stories with a view to improving practice.

Once the midwives had agreed to participate I telephoned them and discussed the project. I then posted them a 'Participant Information Sheet' and a 'Consent to Participation in Research' form for them to read before the interview so that they could think about it further. Not only did I want to interview them but I wanted their feedback on the initial results so that their comments and reflections could be included in the final analysis.

THE MIDWIVES

Sarah has been in independent practice for over 10 years and has practised on her own in a large city centre with back up from other sole practitioner independent midwives. She has a partner and children and is involved with extended family.

Ellen has been in independent practice for 6 years and is part of a practice of midwives in a suburban setting. She has a partner, children and grandchildren.

Laura had been in independent practice for less than a year and is part of a practice of midwives also in a suburban setting. She has a partner and children.

Anna has been in practice for more than 10 years and was part of an independent practice of midwives in a small city. She has a partner and young adult children.

The midwives were busy women in both their work and home lives. I was aware that their time was precious and so was grateful for the time they generously gave me.

THE INTERVIEWS

The midwives were interviewed at a time and place of their choosing. I chose to use an unstructured approach to the interview to give the midwives the chance to talk about what was most important for them. Unstructured interviewing can provide a greater breadth of data compared to a more structured approach (Fontana & Frey, 2000). I was aware though, that I was a beginning practitioner of research, with no previous experience of gathering data by interview, and was proceeding with an audiotape recorder, to interview midwives who I had never met before. I did develop an interview schedule, which I submitted with my Application for Ethical Approval, and I took it to the interviews to keep myself on track in case the conversation dried up or the interview started to get off the subject under investigation. I did not need to refer to it however as the interviews mostly flowed along the same lines as the schedule, and the conversations did not dry up at all.

As well as being a beginning researcher, I was aware that the success of the interview may depend on the approach I took. I decided to take a midwife-to-midwife approach as I felt that the participating midwives may feel more comfortable if the interview was more like sharing of practice experiences that midwives often do with other midwives. I did not want them to feel I was an academic coming to collect information from them or judge them in any way. This type of discussion, midwife-to-midwife, was an approach that I felt I would be comfortable with as well, given my inexperience as a researcher but with 24 years experience as a midwife. Fontana and Frey (2000) write, "this decision is very important, because once the interviewer's presentational self is "cast," it leaves a profound impression on the respondents and has great influence over the success (or lack of it) of the study" (p. 655).

All four of the interviews started by the midwives sharing with me their experience of caring for one particular woman with very high levels of anxiety. Sarah started her interview by saying, *"what probably will be helpful for me is talking about a case that I had last year".* Caring for these highly anxious women seemed to have had a profound effect on the midwives and they shared their practice experiences with me freely and openly. While the interview mainly focused on these women or 'main' stories as I will call them, they did share experience they had had with other clients, talked about their practices settings, client groups, midwifery partners, allied maternity services and their families all in relation to their experiences with caring for highly anxious childbearing women.

In keeping with feminist enquiry I did share my experiences of caring for highly anxious clients with the midwives and endeavoured to develop a rapport with them to facilitate the data gathering-process, and to increase my understanding of their experiences to enhance the validity of the research. Fontana and Frey (2000) write: "increasingly, qualitative researchers are realizing that interviews are not neutral tools of data gathering but active interactions between two (or more) people leading to negotiated, contextually based results" (p. 636).

I did wonder if the audiotape recorder would inhibit the flow of the interviews, but after some initial reticence it did not seem to cause any problems. I was surprised at this as I was advised by my supervisor to use two audiotape recorders in case one failed and the interview was lost. I was concerned that two would make me feel very self-conscious and would really put the midwives off. I did use two and was very grateful for that advice as one of them did not record one of the interviews despite appearing to be used correctly. Once the conversation started the audiotape recorders did not seem to inhibit the flow of the interviews.

I spent between 1 ½ hours to 2 hours with each midwife. There was a short introduction and settling in time of about 15 minutes, and then time was spent on the consent form before the taped interview commenced. The active taped interviews lasted 40 – 45 minutes each. I then turned off the tape when the midwife felt that she had covered the subject or when the tape stopped because it was full after 45 minutes and the midwife did not feel that there was anything more to add. The remaining time was taken up in general discussion that was loosely still related to the topic but was more about midwifery in general. After the interviews I made some notes of my first impression, and especially noted some of the things that the midwives said off tape. A couple of them said some profound statements as I was just about to leave their homes and I found them quite thought provoking so I made notes of these too.

TRANSCRIBING THE INTERVIEWS

I chose to have the interviews professionally transcribed. The transcriber agreed to sign a confidentially agreement so as soon as she returned the signed agreement I began sending her copies of the tapes as I conducted the interviews. While copies of the tapes were with the transcriber I listened to the original tapes repeatedly, especially one where the midwife was very quietly spoken and it was hard to hear her on the tape at times, because I wanted to remember all that was said.

The transcriber sent the transcripts back to me as she completed them. While I knew of the transcribers professional qualifications I did not know anything of her personal details and was concerned that she might be affected by the content of the tapes. I rang her after she had finished the last tape and just made sure that she was feeling alright with what she had heard. Some of the stories that the midwives told were of some very distressed women.

The transcriber and her partner were planning a family soon. She was used to transcribing heartbreaking stories but they were usually about subjects that were not close to her life. She had found that some of the content of the tapes gave her cause for concern so I was pleased that we talked and that she was able to discuss specific issues with me. It was also good to get some feedback from her as she commented on how quickly I was able to establish a rapport with the participants in the interviews. Establishing a working rapport during the interview was what I had hoped would happen with the participating midwives.

DATA ANALYSIS

Burnard (1991) says, "the issue of how to analyse qualitative data remains a thorny one" (p. 465). I felt ill prepared for this part of the research process and yet I knew that the whole project hinged on getting the analysis correct. Mauthner and Doucet (1998) write that, "the question of data analysis has been of great interest to us because it is a relatively neglected area of the literature on qualitative research both in terms of general research texts and also within research accounts of specific studies" (p. 119). Hollway and Jefferson (2000) list four core questions that are connected with qualitative data analysis:

- "what do we notice?

- why do we notice what we notice?

- how can we interpret what we notice?

- how can we know that our interpretation is the 'right' one?" (p. 55).

After reviewing various methods of qualitative data analysis I was feeling undecided. Emden (1998) writes, "different influencing theorists are likely to steer an analysis towards alternative strategies that in turn might highlight different issues and dilemmas"

(p. 39). I did not want to use computer software programs that are currently available because I felt it was not compatible with feminist principles of maintaining contextuality and the level of engagement and reflexivity expected of the researcher with the data. I also only had four interviews to analyse so acquiring and learning a program and the time constraints of the two paper thesis made this not viable.

After a lot of searching and reading, I came across Susan Thompson and Penelope Barrett's (1997) method of data analysis for interviews in feminist qualitative research called 'summary oral reflective analysis' (SORA). This method aims to preserve the richness and contextuality of in-depth interview data within a broader feminist philosophical perspective (Thompson & Barrett, 1997). It was the only specifically feminist method I could find and what was particularly interesting to me was that Penelope Barrett was a midwife and a university lecturer in Sydney, Australia, with an interest in early mothering (Thompson & Barrett, 1997). Barrett used feminist action research to look at mothers' and midwives' experiences in the period covering pregnancy, birth and the first week of the postnatal period to gain better understanding with a view to develop more sensitive practices to enhance the early mothering experience.

Susan Thompson, also from Sydney, Australia, is an urban planner and a university lecturer whose research explored immigrant women's perception of place after they had been through the disruption and dislocation of the immigration experience. While these two researchers come from different disciplines they both shared feminist philosophical views and faced similar problems with collection and, more especially, the analysis of their data (Thompson & Barrett, 1997). They met in a group called the New Paradigms Group which is a supportive group for researchers to air questions, discuss ideas and ask for advice (Thompson & Barrett, 1997).

Thompson and Barrett (1997) developed SORA because they had both collected an enormous amount of primary and secondary data and they wanted to do justice to what they felt was rich material without destroying its contextuality. Another reason I was attracted to this method of data analysis was that, as a beginning practitioner of research, I understood what Thompson and Barrett were writing about. Their explanations of why they developed SORA were clear and the examples of their research, and how they used SORA, enabled me to understand the process and see how

I could use this method of analysis for interview data from a feminist qualitative research perspective.

Thompson and Barrett (1997) feel that SORA contributes to rigour in that it provides the researcher with a technique that can be clearly audited and requires the researcher to repeatedly return to the data thereby increasing the dependability of the research. Thompson and Barrett (1997) also feel this method offers the qualitative researcher another method of data analysis to test trustworthiness of the results by enabling the researcher to use the process of triangulation. Thompson and Barrett (1997) say that SORA is a highly reflexive process and that this is a potent way to ensure dependability and authenticity of the findings. Gillis and Jackson (2000) define reflexivity as "the critical thinking required to examine the interaction between the researcher and the data occurring during analysis" (p. 285).

SORA, as developed by Thompson and Barrett (1997), is conducted using the following steps:

- Firstly transcribe audiotape recordings of the interviews verbatim

- Create a file on computer for 'essence statements and quotes'. Repeatedly read transcripts and listen to interview tapes at the same time stopping to write essence statements and quotes in the file that encapsulated what was being discussed

- On a second audiotape record reflections, ideas and comments and summaries at the end of each 'essence statements and quotes' document

- Blend all essence statements and quotes files into a new document – develop topic groups with accompanying essence statements under themes and sub themes

- Return to audiotaped reflections to advance theorizing

As the transcriber returned the transcripts to me I started to work with the data. I spent some time listening to each tape, and correcting each transcript, to ensure that they were accurate and a verbatim record of the interviews. This time-consuming process made me very familiar with the content of each interview and I came to almost know them by heart. It was also a very good learning tool and I was able to judge my skills and effectiveness as an interviewer. As a beginning researcher I was able to see where I had done well, and not so well. Reading verbatum conversations is quite interesting and a

little strange. A couple of the participants commented on this as well. Thompson and Barrett (1997) said, "interviewees do not speak in paragraphs or lines, and very often, do not use sentences. Individual words are uttered as one idea comes to the fore and as it fades, a new word or phrase emerges as the idea develops" (p. 60).

INITIAL ANALYSIS

When I was sure that the transcripts were a verbatim record of the interviews, I started to form the essence statements and write out quotes that I thought were meaningful. I found this difficult and had to keep the definition of what was an essence statement uppermost in my mind. Thompson and Barrett (1997) say that an essence statement is a statement of between 2 and 10 words that encapsulates the meaning of the subject under discussion. I found that listening to the tapes and at the same time reading the transcripts did bring the transcripts alive and transported me back mentally to the interviews. Just reading the transcripts did not do this, so when I worked with the data I always played the tapes and read the transcripts at the same time. Thompson and Barrett (1997) say "the central tenet of SORA is its ability to preserve data, contextuality, and richness" (p. 56). As I was listening, reading, and making essence statements, I recorded my thoughts and reflections orally on a second tape recorder as I went.

Once I had completed making essence statements and taking pertinent quotes from the interview transcripts, I merged all the statements and quotes into one document. The next step was to work out major topics or themes and sub themes.   Mauthner and Doucet (1998) write:

> The early phases of data analysis can therefore feel messy, confusing and uncertain because we are at a stage where we simply do not know what to think yet . . . . while this sense of not knowing and of openness is exciting, it is also deeply uncomfortable. (p. 122)

I found that I had to write all the essence themes and quotes on a large sheet of paper so that I could see them all at once rather than scroll through a large document on the computer to look for major themes.

I found that I kept thinking about my own experiences of caring for highly anxious childbearing women while I was studying the participant's experiences. Mauthner and Doucet (1998) write that reflexivity lies at the heart of feminist research and that, "reflexivity means reflecting upon and understanding our own personal, political and

intellectual autobiographies as researchers and making explicit where we are located in relation to our research respondents" (p. 121). So it was while thinking about my own experiences, and studying the essence statements and quotes from the participants, that through a discussion with my thesis supervisor three major themes that I felt illustrated the midwives experiences of caring for highly anxious childbearing women emerged from the data. The three major themes were 1) challenging partnerships, 2) making a difference and 3) realizing own limitations.

These three major themes emerged, as a whole, from my overall general feelings, reflections and impressions of all the essence statements and quotes. Mauthner and Doucet (1998) found that in their experience, the initial stages of familiarizing themselves with the data and identifying the key issues was done from more of an intuitive approach, and that after that the later stages of the analysis was done from more of a "structured, methodical, rigorous and systematic" (p. 121) approach. I found that for me this was also true. Once I had the three main themes I then assigned each theme a coloured highlighter, printed off the large combined 'quotes and essence statements' document, and went through all the quotes and essence statements and assigned each one with a coloured highlighter to a major theme. They all fitted into one of the three major themes and there were none left over. I then put the quotes and essence statements, according to their colours, under their corresponding major themes and worked out sub themes that covered all the quotes and essence statements in that group.

I then had my initial results (see Appendix 4). I spent some time reflecting on them in relation to my own experiences. At this point I listened to the tape of my own ideas, reflections, and opinions, which I made during the process of the data analysis and finalized the initial themes and sub themes. The initial themes and the sub themes fitted in with my experience of caring for highly anxious clients like Maree.

In keeping with feminist methodology, I returned each participant their own transcript of interview, along with the initial emergent themes for them to comment on before the final analysis was done, so that their reflections and insights could be considered in the final analysis. As I was working from a feminist approach, I hoped that having the participants assist with analysis, and confirm the results, would increase the trustworthiness and authenticity of the research since I believed that it is the participants who are the 'knowers' of the experience. I was a little nervous of what they would

think. Draper (1997) writes, "researchers face a dilemma if the researched do not agree with the interpretation or even request that the researcher not use the data" (p. 600). This did not happen.

I gave the midwives time to read and think about the themes in relation to their own experiences of caring for high anxious childbearing women, and then I contacted them by phone. They all thought that the initial major themes did illustrate the experience of caring for highly anxious childbearing women. They did not want any of the initial sub themes taken out and could not think of anything more to add. The midwives picked out certain initial themes and sub themes that they felt were more relevant for them personally than others were, but overall they all felt that the main initial themes and all the initial sub themes illustrated the experience. I found, as a beginning researcher, it was an exciting experience to have arrived at this point. The thoughtful feedback from the participating midwives was validation that I was on the right track.

TRUSTWORTHINESS OF THE DATA

A concept that is fundamental to the credibility, or accuracy and honesty, of the data in qualitative research is trustworthiness (Cluett & Bluff, 2000). Measures that I took to enhance the trustworthiness of the data in this feminist study were employed throughout the study from inception of the idea to the writing of the report.

In summary, the main measures I employed to enhance trustworthiness were firstly the way I collected the data. I endeavoured to foster a nonexploitative relationship between myself and the midwives, used an unstructured approach to the interview to give them the opportunity to talk about what was important for them, and strived to develop a comfortable rapport, as Hall and Stevens (1991) argue that rapport building addresses validity as it enhances the accuracy of understanding the participants reality.

Second, I chose to analyse the data with SORA as I felt that it was a method that aimed to preserve the richness and contextuality of the interview data and provided a clear audit trail of the analysis process, from the interview transcripts to the resultant themes, thereby enhancing the dependability and trustworthiness of the data.

Thirdly and most importantly the measure that I undertook to ensure trustworthiness of the data was to return to the participating midwives a copy of their own interview transcript along with the initial emergent themes for validation of the analysis. Hall and

Stevens (1991) write that, "a feminist research report is credible when it presents such faithful interpretations of the participants' experiences that they are able to recognize them as their own" (p. 21).

FINAL ANALYSIS

My next step was to finalize the data analysis. The three main initial themes each had between nine and fifteen sub themes that had been derived from the essence statements and quotes. I went through the same process again with each group of initial sub themes and grouped them into topic groups and again assigned each initial sub theme to a topic group. All the initial sub themes fitted into three topic groups under each main theme (see appendix 5). My final results were three main themes, each with three sub themes.

CONCLUSION

This chapter has discussed and critiqued the research process and data analysis. The next chapter will discuss the results of the research.

CHAPTER FIVE: RESULTS

These themes represent the participant's experiences of working with highly anxious childbearing women.

1   Challenging Client-Midwife Partnerships

- Experiencing intense relationships

- Experiencing stress

- Forming boundaries

2   Making a Difference

- Showing commitment

- Giving support

- Experiencing professional satisfaction

3   Realising Own Limitations

- Seeking peer support

- Experiencing lack of knowledge

- Referring client on for further care

These themes and sub themes illustrate where the difficulties for the midwives lay when caring for highly anxious women. They illustrated the commitment, concern and the satisfaction that the midwives experienced while caring for highly anxious women, and they showed that the midwives needed help and support as they experienced lack of knowledge about mental illness, and had difficulties referring highly anxious women on for specialist maternal mental health care. While the experience was professionally satisfying as the midwives believed they made a difference, it was sometimes stressful, frustrating and draining.

During the interviews we shared midwifery stories of caring for women who were highly anxious. The midwives started the interviews with a main in-depth detailed story

that they shared with me. When they had finished their main stories they went on to tell of other experiences of working with anxious women, with general discussion around the subject.   The stories were of very different midwifery care situations but the main themes of 1) challenging client-midwife partnerships, 2) making a difference and 3) realising own limitations, did describe the midwives experiences of caring for these highly anxious women.

CHALLENGING CLIENT-MIDWIFE PARTNERSHIPS

This theme was, for me, the most obvious and the midwives openly shared their difficulties caring for highly anxious clients over the weeks and months they were working with them. Under this main theme three sub themes emerged from the data, those of: 1) experiencing intense relationships, 2) experiencing stress and 3) forming boundaries.

EXPERIENCING INTENSE RELATIONSHIPS

Intense relationships

Sarah, *"it wasn't about the number of visits, it was just the intensity, you know"*.

All the midwives talked about how intense the women who were highly anxious were and just how intense the relationships with these women were. Ellen said that the woman in her main story had a lot of friends and family but "*she always rang me. She said "I have rung my Mum or I've rung my friend but I thought I would pass this by you". So she had this huge amount of faith in me and trust to the point of being extreme"*. The midwives felt quite drained by these intense relationships.

Needing more time

All of the midwives said that highly anxious women need more time. Sarah said of the woman in her main story *"she was very time-consuming . . . that's one thing that really, you know. You've got a time frame"*.

The highly anxious woman also demanded a lot of visits. The women in Ellen's main story required not only a lot of antenatal care but postnatally the client's anxiety levels rose, "*I saw her everyday for four weeks. (laughs). I had to pop in every day, I tried not to go, but the day I didn't go, she'd be ringing me up"*.

Receiving more phone calls

Phone calls were a big problem when caring for highly anxious women. The midwives found this one of the hardest issues to deal with. Ellen: *"Phone calls and I don't exaggerate it she would be ringing about three or four times a week. Evenings, Friday evening – every Friday evening, every Friday evening"*. Ellen said that this client rang her every day from 36 weeks till delivery and even after she was discharged postnatally the calls kept coming.

Ellen: *"it just got to where my mobile would go, and I'd see her name come up and I am happy to tell you that I didn't actually answer all her calls. I would just turn it off, I'd let it go to message. And then she would leave a message and I'd calm my self down and then ring her back"*.

The midwives said that the highly anxious women often called 'out of hours' which they found stressful. Laura: *"She rang me a lot the whole way through, with symptoms. There would be a lot of phone calls at 3 o'clock in the morning to the point where I seriously, you know, like I really wanted to get rid of her, and it sounds awful, but it was affecting my home life. You know, the home phone was ringing at 3 o'clock, you know, sometimes four nights in a row"*.

Experience more physical symptoms

The midwives found that the highly anxious women seemed to have more physical symptoms that worried them. The literature I reviewed supported the midwives observations (Andersson et al. 2003). These symptoms often turned out to be normal symptoms and nothing was actually wrong. They just needed information and reassurance and sometimes at 3 o'clock in the morning. Anna: *"Youngish unsupported women, who don't know their bodies, who can't recognise the signs of what's right and wrong and don't read books and talk to other people, they rely on us heavily . . . . and we do talk with them, talk it through how disturbing it can be, waking up the midwives in the night, perhaps there are things that can wait until 8 in the morning. Some respond to this and some don't"*.

 The midwives also spoke of the concern that they would miss something important because of the increased number of symptoms the anxious women complained of. They worried that the stress they experienced from the frequent calls with symptoms would diminish their listening skills and they would miss something significant.

Ellen: *"You know, trying to balance, deal with these really acutely anxious women. Deal with it yourself and dealing with your family . . . . and still trying to take these phone calls and still trying to do it (midwifery) and not miss anything"*.

Narcissistic tendencies

The midwives all said that highly anxious women appear to have very narcissistic tendencies. They become so distracted by their own worries that they forget that the midwife has to eat and sleep, care for other clients, and have a personal life and time off. Sarah told me that she was once ending a long home visit with a highly anxious client and they had had a lengthy discussion when she received an emergency call on her cell phone. *"I needed to go. I explained to her I had to go. . . but it was so difficult to get out of her house – cos it was really hard work just to stop her talking, um, you know, and I found that really difficult. And you know like, she wasn't an insensitive woman at all – but she just couldn't care that I actually had to get up and go . . . . and you can interpret it as rudeness, but it's not really"*. Sarah.

Slow to develop trust and clients withholding important information

These problems seemed to go hand in hand. Throughout these challenging client-midwife partnerships the midwives all said that despite the frequent calls and high levels of anxiety the women often withheld vital information from the midwives. It took a long time for trust to develop in the relationship. In Anna's main story the woman never told her what was really going on for her. Anna: *"I was never privy to what was going on"*.

Sarah: *"But I couldn't really see what all this was about, this kind of ringing me up every five minutes . . . . on about the third visit (postnatal) she was a bit more relaxed and just out came this tale"*. Sarah said she wished that she had known what was really wrong early on as it would have made a big difference to her understanding of the situation that the client was in.

Anxious women reluctant to receive care from back up midwife

The midwives found that highly anxious women were sometimes very reluctant to receive care from back up midwives when they had either been up all night or were attending another client's birth. This put the midwives under increased pressure.

Ellen: *"They (anxious women) were not very good at accepting other midwives coming on . . . . no it's 'I'll see you when you finish'. And I've driven home at 8 o'clock at night when you really just want to go home, have your dinner and a shower and see your family, and you end up calling in someone's house, on the way home, to spend half an hour reassuring them that they're okay".*

Difficult to terminate relationship at six weeks with anxious clients

All the midwives said that while it is usual for women and the midwives to sometimes feel sad at saying goodbye at the end of the midwife-client partnership, for these highly anxious women it is especially difficult. The woman in Ellen's main story kept ringing Ellen for weeks after she discharged her. Ellen met the woman's partner months afterwards and he said 'she never stops talking about you'. For the midwives it is often a relief to discharge these really anxious women.

Anna: *"At least we have an end to these relationships".*

Laura:*" So that was another one where I walked out, you know, after that discharge, I just walked out with a huge sigh of relief just like a big weight had been lifted off my shoulders".*

Midwife experiences stress and questions her career choice

The midwives did find these highly anxious clients stressful at times especially considering the length of time they had these women in their lives. Ellen said that after caring for the woman in her main story, *"I couldn't believe it, and it was my first year of being in independent practice and I nearly threw in the towel, but for colleagues saying look this is not normal".* Laura: "*It's cases like that that make you question whether you really want to be doing this job".* The midwives had to cope with these anxious women, their other clients, and try and have a personal life and the needs of the highly anxious clients made this sometimes very difficult. Sarah said her anxious client from her main story was, *"impinging on my life".*

Poor collegial support and lack of information sharing increased stress levels

The midwives found that where there was poor support and communication from doctors, hospital staff or mental health services, the stress of caring for highly anxious

clients was increased. Ellen said *"I rang the GP at one stage and he said I thought you might have problems with this lady . . . I was really angry with the GP . . . . it would be good if he had given me a bit of a background."*

Laura told me that a GP handed over LMC care of the woman in her main story when she was at 20 weeks gestation and failed to tell her that this woman had an extensive psychiatric history. Laura only found out after the woman was admitted to hospital in distress and she read about it in her medical records. Laura said, *"I really think he was looking to get rid of her"*. Laura struggled on with this woman and things only improved for Laura and her client once the local maternal mental health services were involved and the hospital core midwifery service offered to help Laura with the midwifery care. This help took weeks to put in place though and Laura was very stressed in the meanwhile.

FORMING BOUNDARIES

The midwives all said that the longer they practised the more they came to realize that if they were to survive in the job they had to define the boundaries of the client-midwife relationship. While caring for very highly anxious women this is easier said than done. Ellen cared for another highly anxious woman not long after the woman in her main story. She said, *"I set up a few boundaries, and it worked, it doesn't work for everybody"*. That was a common theme in the data; some women respond and some do not. When Laura and I were talking about defining boundaries to the relationship Laura said, *"I'm starting to find I have to... more and more that I have to... I really have to"*. Anna: *"in a way you have to protect your self . . . . we have to put barriers in place . . . with them not abusing our system, our free 24/7 counselling service, both for physical and the mental issues. And some people need to be spoken to quite firmly about that."*

MAKING A DIFFERENCE

This theme of 'making a difference' was clearly evident in the data. It was strongly interwoven throughout the midwives' stories and experiences. Three sub themes also emerged from the data when looking at this main theme. There were, 1) showing commitment, 2) giving support and 3) experiencing professional satisfaction.

SHOWING COMMITMENT

The midwives felt a deep sense of commitment to anxious women despite that fact that the relationships were so challenging. Sarah said that working through clients' anxieties was part of our everyday midwifery work. Sarah: *"I think that that's just our bread and butter work isn't, it's our normal day, talking people around it"*. Laura also talked about her sense of commitment to the woman in her main story, *"and that's the only thing in the end that kept me on that case"*.

Prepared to persevere with relationship if has good rapport

The midwives were happy to persevere with these challenging relationships if they felt they had a good rapport. While discussing this with Sarah she said was happy to persevere and go the extra mile with the highly anxious women, *"as long as we're getting on, we like each other, I think that's the critical thing, I think it's really really important . . . . I wouldn't want to put up with people playing games with me if we're not getting on. That's too difficult"*. Anna found some of these highly anxious clients were very likeable, she said, *"some of these people are . . . quite characters"*. I have also found this in my practice also. I remember while caring for Maree, she was possibly the most demanding woman I have cared for, there were some days when I just got so frustrated with her I sat down with her and laughed and she would laugh too. We had a good relationship and it survived intact throughout my time with her. Caring for her would have been too hard if we did not have a good relationship.

They also felt that it was sometimes better for the client if they carried on with caring for these clients because it would be just too difficult for another midwife to take over at that stage, even thought the midwife felt she had had enough. Anna said, *"you hesitate to pass them to another midwife because you've go so far into that relationship that it's sometimes easier, than for someone else, if you just carry on"*.

Taking more time and doing more visits

All the midwives said that taking more time and doing more visits was a major feature of caring for highly anxious women. Sarah: *"when I think about it, the only way that I'm consciously aware that I will practise differently with someone who is really anxious because I slow everything down to snail's pace, and just be prepared to sit there for longer because it does take longer because people can't hear you when they're really anxious, say, you know, you have to be prepared for it to come down a few cogs*

before they're even listening to information". Ellen said of the women in her main story that along with a lot of phone calls *"I did a huge amount of visits as well"*.

Continuous careful assessments

The midwives found that it was difficult to work out just what was going on with the highly anxious women and their babies sometimes, because of the increased complaints of physical symptoms, and because of being afraid of missing something. They found they had to be very observant. It was a balance between putting in boundaries to the relationship, giving information and reassurance, trying to keep them calm, and, at the same time, not missing anything that might need further investigation. The woman in Ellen's main story constantly called towards the end of her pregnancy because the baby was not moving. Ellen said she did a lot of antenatal assessments and monitored the baby frequently. Ellen: *"I was actually scared the baby was going to die and I was going to be sued and feel guilty for the rest of my life. Because it was like, to me, the boy who cried wolf with these people. The ones who drive you mad with the phone calls and the moans and the groans, and you find you are going to miss something"*.

GIVING SUPPORT

Support and encouragement

A common theme running through all the midwives' main stories was the lack of support for these women. Relationship problems were common; lack of extended family support played a big part, as did previous mental health problems as well as previous traumatic birth or life experiences. The midwives went to great lengths to give these women extra support and encouragement as demonstrated by the level of care given in their stories. Sarah said, *"and they really appreciate you focussing on them and talking which is good . . . . I felt that it was good for her to have someone who could take the time"*.

Laura's client in her main story called for help in distress continuously. Her family and the family doctor had given up on her as they thought she was 'crying wolf'. Laura said, *"I would always go and see her"*.

Building confidence

The midwives talked about how they have to give the women information to enable them to feel as though they could cope with childbirth and early mothering. An example of this, that the midwives gave was the high number of women who they felt, these days, have no knowledge or experience of babies. Ellen: *"a lot of first mothers have never even held a baby . . . . they don't know what to put on them"*. The midwives were concerned about the apparent loss of mothering knowledge that is usually passed down through families. Very inexperienced new mothers can be very anxious. Laura: *"Often I'll go, you know, and people are 36, 37 weeks pregnant and they're sort of getting all their things together and often I'll be there showing them how to make up the cot or this is how many layers you should be getting. All these things, people would have known"*.

Anna: *"Whenever I do my hospital tours I try and borrow a baby . . . and show these new parents a new baby. It reduces them to tears sometimes – they've never seen a baby before. They've got no idea. Hm, so a lot of work has to go in antenatally or they'll go into postnatal shock"*.

Being understanding, feeling empathy and demonstrating patience

The midwives understood why many of their clients were so anxious. They talked about the different client groups such as immigrant and refugee women; women with poor obstetric histories; young unsupported women with very little knowledge of themselves or pregnancy; women with previous or ongoing mental health problems; women who had had previous traumatic birth or life experiences; and women who had relationship problems.

Some of the midwives were concerned for a growing group of women who seem very anxious: the professional working first time mothers in their late thirties or early forties who work full time until late in the pregnancy. Ellen: " *...a lot of them are busy working mums as well and they're working until the day of the delivery . . . . they're not getting time to actually – I hate the word "nest", but I'll use it – because they're not getting time to actually sit down and think I, we are going to have the baby in the next few weeks. We are going to become a family and that psychological as well as physical prepping – they're not doing that anymore"*.

Laura told me a story of an immigrant client who had just arrived in New Zealand at 34 weeks pregnant. She was expecting her first child and had no friends or family in the country. *"I went to see her and she was so wound up she was unable to sit down, she was so wound up. She expressed huge anxieties to me, she was absolutely panicking about this baby – she was expecting the worst out of everything. She thought the baby was going to die, she didn't think that our health system was very well prepared, she just had no idea. It took me a lot of work. I saw her twice a week, every week, until she had that baby, um and post-natally it was an absolute nightmare, she used to page me at the hospital, crying, sobbing over the phone".*

The midwives showed empathy with the mothers who were so distressed. They were all mothers themselves and they did refer to their own experience of childbearing and early mothering. They remembered how stressful the experience could be. Sarah said: *"the actual, like, taking care of the baby, that was, that was lowest on my list of things to worry about. But that was the thing in the end that was the most difficult".*

 The midwives all said that sometimes the most difficult part of caring for highly anxious women was in the early mothering period. The women's anxiety seemed to peak with tiredness from the labour and birth, and the demands of caring for a new born. After Ellen's client from her main story delivered her anxiety levels rose. *"My colleague said, oh you will be fine now she had delivered, and it went worse. And it went a lot worse actually".* This was the woman who Ellen saw everyday postnatally for four weeks.

Advocating for clients to ensure appropriate care in hospital

The midwives found that they had to ensure that the highly anxious women's time in hospital was as stress free as possible. They visited these women frequently in hospital. I know from my experience as a core midwife working in hospitals that very anxious women find it a difficult time with the frequent changes of shifts and staff. Being away from home and their usual supports and having to share rooms and facilities with other clients with babies, and trying to get enough sleep in the sometimes noisy hospital environment can be very anxiety provoking.

Anna's client from her main story wanted an elective caesarean birth. She had had a previous caesarean birth, after a long traumatising labour, for fetal distress. She then

developed postnatal depression. Anna said that this client also had other traumatic experiences in her life that she wanted to keep confidential and Anna respected that.

Anna set up an appointment with the obstetrician and ensured that he was fully informed of her mental state and problems before the client went to see him to discuss having an elective caesarean birth. Anna drove her to the hospital and stayed with her for the caesarean and waited till she was recovered and settled post operatively. The client's partner declined to come with her to support her. *"Unfortunately one of the clinic letters was missing from her notes so I had to get round and talk to the anaesthetist about the issues so that she was not questioned too much about why she was having an elective caesarean".* This woman did have a few problems relating to the staff, and was stressed while in hospital, so Anna arranged for her to be discharged early and she cared for her at home.

Giving, repeating and clarifying information and ensuring informed choice

The midwives found that childbearing women who were highly anxious often have trouble taking in, retaining, and processing information. The information given often had to be repeated and clarified untill the women were able to process it and make informed decisions. Anxious women often have trouble problem-solving, particularly when caring for the baby.

Ellen: *"She wasn't taking any information in. They were very basic questions, they were like a 13, 14 year old might ask if she was pregnant, you know those sorts of anxieties. And it was like she hadn't actually learned anything from the first pregnancy, birth or aftercare . . . like she hadn't actually taken anything on. It was like a whole new experience and whole new anxieties".*

Giving information and ensuring the clients make an informed choice is a vital part of our care. It is a required standard of midwifery practice (NZCOM, 2002) and this can be challenging when working with highly anxious women. I remember Maree ringing me up and asking me questions about subjects that I had just spent one and a half hours discussing with her at the previous visit that I had with her that day. I just had to patiently go over it with her again.

Sarah: *"I just need to be prepared to slow down and give them (anxious clients) more time and just, helping them, you know, increase their confidence in what's going on so they're well informed of what their choices are and, um, that they've by then got a lot of*

confidence in me, that they know that I know what I'm doing, and basically that I'll make sure nothing awful happens to them".

EXPERIENCING PROFESSIONAL SATISFACTION

While the midwives did find caring for highly anxious clients challenging, they did find it professionally satisfying and rewarding work. I can remember feeling a great sense of achievement when Maree and I arrived at the point where I could discharge her. While I felt exhausted, overall I felt very satisfied to have helped her over this stressful time in her life.

Sarah: *"I often find that people like this woman, um, it can be quite satisfying working with people like that, because you really do know you've made a difference compared to somebody who's a lot less kind of needy".*

REALISING OWN LIMITATIONS

This was the third main theme that emerged from the data. The midwives did identify when they had reached the end of their scope of practice or ability to meet the needs of their highly anxious clients. Three sub themes again were also evident with this main theme. They were, 1) seeking peer support, 2) experiencing lack of knowledge and 3) referring clients on for further care.

SEEKING PEER SUPPORT

Enlisting assistance of other midwives to help care for anxious clients

The midwives found that they needed help caring for highly anxious women. Overall the midwives felt that it was helpful to involve their practice partners with the care of highly anxious women. Ellen: *"I don't think you should have one person (midwife) the whole time. Because I think it's too much".* She felt while continuity of carer was good for the highly anxious women it was not good for the midwife.

Anna felt that as midwives we need to help each other with challenging anxious women. Anna: *"within our practice, we identify these women, so that when we have a weekend off, the others know that um this person or that one may be ringing excessively".*

Anna: *"our group of (the number) work in extremely well together but I know other midwives who choose to practice more independently , more on your own, perhaps*

loosely with a couple, they must have great difficulty sharing these problems (caring for highly anxious women)". Sarah did tell me that as a lead maternity care midwife, not working in a group practice, she found that working with highly anxious clients on her own was challenging.

The midwives enlisted the help of their practice partners and the core midwives in the hospital. Sometimes the help was offered when other midwives recognized that they were struggling to cope with the clients needs. Ellen: *"She (the client in labour) lost the plot and it brought it all back again, her last labour which wasn't pleasant by the sound of it for her, and the team leader in the deliver suite recognised that I looked quite stressed and I'm not normally as stressed but she said are you okay . . . . do you need that midwife to help and I said yes I do"*.

Debriefing with midwifery colleagues

Anna, Ellen and Laura all worked in group practices and they regularly shared with the other midwives their practice experiences and challenges.

Anna: *"We meet weekly and most of our talking – first of all we talk about the births that we've had during the week, and then we talk about any on going problems"*.

Sarah, who practised on her own, said for her that sharing practice experiences and challenges in the tea room with other midwives at the hospital was an important form of debriefing and getting things off her chest. This was an important source of support for her.

EXPERIENCING LACK OF KNOWLEDGE

The midwives often felt that they didn't know enough about their highly anxious clients and their backgrounds and when they experienced difficulties with caring for them had to find out more information. As the data showed the women often withheld information which the midwife would have found helpful and the referring health professionals, especially the General Practitioners, sometimes do not supply enough background information.

Anna: *"And that's another area where I see where we could do better collegially, sharing information. Back and forth"*.

In the interviews I asked all the midwives did they feel that their midwifery training prepared them for dealing with maternal mental health problems? Anna said that she felt that her training *"absolutely"* did not prepare her for dealing with maternal mental health problems in practice.

Sarah: *"No – I just knew it in theory"*.

Ellen: *"No, definitely not. I actually did mine in '89, traditional hospital (midwifery training), and I don't remember doing any psych"*.

Laura: *"I think in part . . . . I think probably the extent of the education we got during our training was um, a very frank discussion about what some women will expect from you and more and more we see anxiety manifesting in women particularly because they have so much going on in their lives that um, a pregnancy and a baby just adds to the stress and can sometime, you know, kind of blow it away. So I think we had a reality check, certainly, about what to expect, but probably no actual training as such"*.

Seeking professional development

The midwives did find that they needed more information about maternal mental health. Anna, at the time of the interview, was just about to start on a post graduate study course on maternal mental health.

Anna: *"I think when we were younger midwives we concentrated more on the physical to some extent"*.   After 10 years in practice and having reduced her work load, Anna found she had become interested in the subject of maternal mental health issues.

Anna: *"it's just so much a part of our lifestyle now, is these mental health issues. They don't have to be major but if they're handled right, it might just mean one person actually listening. Makes such a difference. So um, that's why I decided to do my paper really. I've got the interest and I've got the time"*.

REFERRING CLIENT ON FOR FURTHER CARE

Referring to other midwives

The midwives did give instances of when they felt that they had to refer highly anxious clients on to other midwives for further care. They did say that if they felt that the relationship was not working they would assist the women to find another midwife for

their own and the women's sake.   They also said that they would assist anxious women to find another midwife if they had too many anxious women at one time, or if they had had one after another, or if they felt that a client was going to place too many demands on them at a time when they felt they may not be able to meet those demands.

Anna: *"I have had a couple (highly anxious clients) in my practice and their anxiety in the antenatal times, their demandingness, I suppose that can be different to anxiety, but I have actually found them other midwives, because I have realised, recognised that it's all going to be too much for me. There were a couple last year when we were a bit stressed, as a family, but I knew that I had to pull out. From there they proceeded to go on and be anxious with another midwife"*.

Referring for specialist mental health care

The midwives did refer highly anxious clients on for specialist mental health care when they felt that the women's needs went beyond their scope of practice. There were maternal mental health services in the areas were the midwives worked but they had mixed experiences of working with the mental health services. Once the women were accepted and treatment had commenced they said that the support and communication from the services was very good, but they often experienced delays and/or the clients didn't fit the criteria for referral. The woman in Ellen's main story did not want to see a mental health professional and she seemed obsessed with Ellen. As Ellen said, "*she had this huge amount of faith in me and trust to the point of being extreme"*.

Sarah said that it was *"very very hard to get into the maternal mental health service"*. Sarah had a client who was in need of mental health care who had to wait a month for an appointment. Sarah: *"I was quite shocked . . . . there was this specialised group of people who are meant to be there for this very thing and here's a woman who, there was no two ways about it, she needed help and they just weren't there for her, you know. It was like pulling teeth and their response was; we're pleased to let you know, that we've accepted her, we will assess her, but we can't do it until the end of the month and this was like the beginning of the month."*

While this woman was supported by Sarah, the family doctor, and her family, Sarah found this delay stressful as she felt the woman required care that was out of her scope of practice.

Sarah: *"I mean I can do nothing really, but my fear was that she might kill herself. I didn't really think she'd do anything to the baby. My fear was that she'd kill herself, you know, you're aware as a health worker that you're responsible if you know somebody's really sick, you don't want to be saying afterwards, well I thought she'd be alright".*

CONCLUSION

These three main themes and corresponding sub themes describe Sarah, Ellen, Laura, Anna's experience of caring for highly anxious childbearing women. Apart from Laura, the midwives have had many years of midwifery experience. I hope that these themes will help midwives, especially new midwives, increase their understanding of what it can be like when working with highly anxious childbearing women.

CHAPTER SIX: DISCUSSION

The midwives were the primary focus of this study but listening to their stories of the clients it was difficult to separate the needs of the two groups. The women in the stories were, at times, extremely distressed during the time they were being cared for by the midwives. I found myself sharing the midwives' concerns for the women, as well as feeling concerned for the midwives, as they endeavoured to provide effective care for these stressed and anxious women.

PARTNERSHIP – HOW WE WORK WITH WOMEN

New Zealand midwives work from a women-centred philosophy in partnership with women (NZCOM, 2002). The midwives who participated in this research said that it was sometimes hard to feel as though they were in a 'partnership' relationship with their highly anxious clients. Anna: *"it can be a very selfish partnership"*. They did not feel the partnerships with the women in their stories were based on the principles outlined by Guilliland and Pairman (1995) of individual negotiation, equality, shared responsibility, empowerment, informed choice and consent. The women's anxieties seem to interfere with their ability to form reciprocal relationships.

Pairman (1999) states that:

> Partnership is always challenging and it always involves learning. Sometimes it will be easy and you and the women understand each other very well and it feels great. More often though it will be hard work and asks a lot of us as midwives. (p. 9)

The relationships that the participants had with the highly anxious women in their stories were very hard work. Midwives therefore have to find ways to work safely with women who cannot easily form reciprocal partnerships with them.

SUPPORT

Providing support and information is a large component of our midwifery care (NZCOM, 2002). Throughout human history women experienced in birthing have supported other women to give birth. Oakley (1992) maintains that support decreases stress by acting as a buffer to stress, reducing the likelihood of experiencing stress and assisting recovery from a stressful event. Mander (2001) breaks the concept of support down to emotional, instrumental, informational and esteem support. Emotional support

involves listening, showing concern and intimacy. Instrumental support is the provision of goods or services. Information support is giving information at the right time to help with decision making in a time of stress, and esteem support is usually given by a trusted and familiar person to the one under stress to strengthen their self belief. Wheatley (1998) states that the amount of support a person needs depends on their individual personality, coping style and problem-solving skills. People will be emotionally satisfied if support is acceptable and available (Wheatley, 1998). The outcomes of acceptable and available support, as outlined by Wheatley (1998), are reduced anxiety, less antenatal and postnatal depression, and improved self-esteem and confidence as a mother.

Midwives become important sources of support for childbearing women. This is the part of midwifery that provides so much job satisfaction, as we know that we are doing something that is helping other women and their families.

Guilliland (2004) says:

> I have always believed that all professional service provision exists to fulfil mutual needs between client/patient and practitioner. That is, the benefits are reciprocal and that we work at what we do because we need certain things it offers us and, in turn, the work we do fulfils a need in others for the service we offer. (p. 5)

The women in the midwives' stories all had problems with lack of support in their lives. Most of the women in the midwives' stories looked to the midwives for an extraordinary amount of support and information. As the themes showed, the highly anxious women placed considerable demands on the midwives. The midwives wanted to provide the level of care that the women felt they needed, but in some situations the demands were almost more than they could cope with. The midwives, being aware of their own scope of practice, often wanted to refer the highly anxious women on to a mental health professional but there were frequent time delays, or the women did not fit the criteria for referral, or the woman did not want to be referred resulting in more pressure being placed on the midwife.

The midwives often experienced high stress levels. They were willing to go the extra mile but sometimes that extra mile became too long. If midwives do not protect themselves from stress in practice they will eventually become disillusioned with midwifery and are in danger of developing psychological problems themselves. The

demands of caring for highly anxious and needy women did make the midwives in the study sometimes question their career choice.

Browne (2004) asks, "have you got a plan to protect your best asset – yourself" (¶ 4). She asks an interesting question especially when caring for women who do not place boundaries around their relationship with their midwife. As midwives we take ourselves into the partnerships with our clients along with our professional body of knowledge. This makes midwifery satisfying for both the midwife and the clients. It can also make us vulnerable to stress if the other partner has unrealistic expectations of the care that the midwife can provide. For midwifery to be sustainable we need to protect ourselves from undue work stress. Health professionals can develop burnout if they have too high expectations of themselves (Mander, 2001). Mander (2001) describes burnout as "a maladaptive form of psychological accommodation" (p. 140). It starts with emotional exhaustion leading to the person becoming isolated from colleagues and clients and finally the person suffers from reduced work performance (Mander, 2001).

We need to arm ourselves with enough professional support and knowledge so that we can deliver high quality and effective care that is satisfying for both the midwife and childbearing women. The midwives in the study had suggestions, which they had gained by experience and reflection, for surviving the experience of working with highly anxious childbearing who placed great demands on them. These were based around negotiating mutually acceptable midwife-client relationship boundaries, seeking support, referring to mental health professionals and professional development.

SUGGESTIONS FOR PRACTICE

When reflecting on the results of this study and considering their implications for practice, education and further research, the concept of generalisability needs to be addressed (Gillis & Winston, 20002). The generalisability of a study, sometimes also referred to as external validity, is the extent to which the results from the group studied can be thought of as pertinent to other simular groups (Gillis & Winston, 2002). In this study the themes describe the experiences of Sarah, Ellen, Laura and Anna only and therefore are not generalisable or applicable to all midwives. I saw this study as a 'beginning place' to look at the midwives experiences of working with highly anxious women. The study is therefore limited by the small number of participants and the fact

that the methodology and design were aimed at gaining understanding of these four midwives experiences only. Suggestions for practice therefore have been informed by the results of this study and by other midwifery research and literature.

FORMING BOUNDARIES

All four of the participating midwives talked about the need to define and set mutually acceptable boundaries to the midwife-client relationship if they were to survive as an independent midwife. This need for relationship boundaries, in order to make independent midwifery sustainable, was also highlighted by Engle (2003) and McLardy (2003) in their research. Engle (2003) writes, "keeping the balance between job satisfaction and setting boundaries around one's practice was seen as integral to the sustainability of practice by each of the participants in the study" (p. 15). There is a difference between midwives creating protective barriers to separate work life from personal life and negotiating mutually acceptable effective boundaries to the midwife-client relationship in the true spirit of partnership.

Relationship boundaries, that suit the midwife and the client, need to be negotiated at the beginning of the relationship. However, as the midwives said, some of the highly anxious women respected these boundaries and some did not. When the women did not respect the negotiated boundaries, the midwives found it frustrating and arduous. In this study the midwives experienced stress as some of the highly anxious women called the midwives very frequently and at any time of the day or night with little regard for how this may affect the midwife. Midwives, setting up in practice, may need to form buffers or barriers such as not having her name and the address of her home in the phone book; using a telephone answering service, or using a separate telephone land line for midwifery calls at home so that phone calls can be diverted to her back up midwife when she is having time off. Also, as Ellen found, caller identification on cell phones and land lines is useful so that the midwives can let the call go to message, as Ellen did, while she mentally prepared herself to speak to anxious frequent callers if she was feeling stressed or frustrated.

How to manage when clients do not respect the boundaries is something that midwives and midwifery practice groups need to work out for themselves. We will all have different limits. I do not see an easy or simple answer to this problem. Midwife, Joanne Dozor (2001) says, "we have all dealt with women who are extremely needy and

demanding. If a woman does not respond well to healthy boundaries you set for yourself as a midwife, then you are in trouble. Each of us must decide what limits are healthy for us" (¶ 2). The midwives in this study were committed to the women in their stories despite the challenging relationships. They experienced a lot of job satisfaction because they believed that they made a difference.   Maybe the answer to how you manage these situations is not so much in tightening the boundaries but in negotiating a compromise with the woman and enlisting more help and support in order to care for the women effectively. We must not make our boundaries so tight that our client relationships are ineffectual. If the partnership model of care is not able to be achieved with some clients then we must find another way.

Skinner (1999) says that for some clients working in partnership at practice level is not always possible or desirable. Skinner writes, "to insist on partnership as a model for all does presume a homogeneous population both willing and able to be partners. This will never be true" (p. 17). Skinner (1999) suggests that midwives could work with women using the principles proposed by Parker (1997) of, "sensitivity, skill and respect" (p. 17). In my experience working with highly anxious women does require a lot of sensitivity, a high level of skill, and a non judgmental and respectful approach.

ENLISTING SUPPORT

The midwives in this study all talked about the importance of the support they receive from their midwifery colleagues. Ellen, Laura and Anna found the support offered by their practice partners vital. Sarah, as a sole practitioner, also sought out the support from other midwives with whom she regularly worked as she found caring for women with high levels of anxiety very challenging.   The amount of support each midwife will need will vary from midwife to midwife. Beginning practitioners will be more in need of support and information, especially when in her first year of practice, as Laura was, when she was faced with clients with complex mental health needs.

While continuity of carer is good for the highly anxious childbearing woman and is an expectation of the midwife-client relationship, it is sometimes too much, as the results of this study showed, for the midwife providing the care. Enlisting the help of another midwife to share some of the care of these highly anxious childbearing women will ease the burden even if the woman takes a while to get used to the idea. As Guilliland (2004) says, "with all relationships negotiation and compromise are not always easy.

Expectations are not always met. Some women are not interested in working in partnership and sometimes the compromises seem very one-sided for both the midwife and the woman" (p. 29). I feel that with women with mental illness it is not a matter of not wanting to work in partnership it is a matter of not being able to easily.

It is safer for a woman and her midwife to have two unstressed midwives involved in her care than one stressed midwife. The LMC, while still retaining the role, could delegate some of the care to her practice partner or back up midwife. They could care for these women together. This would give the LMC midwife some space and allow the woman time to get to know the back up midwife in case the LMC midwife needs a break. Midwifery help can come not just from practice partners, but other LMC midwives and hospital core midwifery services. For the good of the women and the midwives, it may require a blurring of the lines of demarcation of maternity services. The needs of the women and the safety of the midwives should come first, and for some women with complex mental health issues and difficult family situations, flexible and creative solutions to meeting their needs have to be explored.

Midwives need to remember that high levels of stress hormones do affect memory (Newcomer, Selke, Nelson, Hershey,Craft, Richards, & Alderson, 1999) and so having two midwives involved in the care of highly anxious clients does mean that the midwives can back each other up if the client is confused or if there are communication and decision making problems. At the beginning of the midwife-client relationship giving explicit explanations of how you work with clients, working out mutually acceptable boundaries together, and careful documentation is also good practice when caring for all women, but particularly highly anxious women. Careful documentation of all interactions and the support of another midwife will offer the midwife some protection if the client does consider initiating complaints procedures if she has unmet expectations, or is unhappy with the outcome or aspects of her care.

DEBRIEFING

Another form of collegial support that the midwives in this study found vital was the ability to talk about practice experiences, share practice challenges and generally debrief with each other on an ongoing basis. The term 'debriefing' may not describe this interaction correctly. The term 'defusing' may be more appropriate. Weaver (n.d.) says,

"defusing is the term given to the process of *talking it out* . . . . the defusing process usually involves informal and impromptu sessions" (¶ 1).

For the midwives working in group practices the weekly practice meeting was a valued time together. Having a forum to 'talk it out' helped to sustain them in their practice. It is a professional expectation and responsibility that midwives support and sustain each other in practice and share their practice wisdom (NZCOM, 2002). However when a midwife is experiencing high levels of stress and emotional fatigue she may need more than the opportunity to debrief/defuse with a supportive colleague. It may become a burden on the relationship trying to cope with each others stress. The support may need to be more formalised and the concept of clinical supervision in midwifery is now being considered by the some members of the midwifery profession in order to protect and sustain midwifery, and ensure excellence in practice (Mander, 2001; Skoberne, 2003; McLardy 2003).

CLINICAL SUPERVISION

Skoberne (2003) writes, "clinical supervision can help the midwives to reduce stress and prevent emotional fatigue, which often leads to lack of both enthusiasm and motivation at work" (p. 66). Clinical supervision is a concept and practice that is considered important for health professionals working in the field of mental health so that they sustain themselves and develop professionally (Mander, 2001). Lyth (2000) says, "clinical supervision is a support mechanism for practising professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills" (p. 728). This professional growth through clinical supervision is achieved through the process of reflection (Derbyshire, 2000).

Midwifery should consider this form of support from a trained professional clinical supervisor. If clinical supervision is a regular and ongoing feature of professional practice then midwives will be sustained in their practice mentally and emotionally, will develop knowledge, skills and strategies for surviving these intense and difficult client relationships, and will be protected from burning out. This process would not only protect midwives but will protect clients as well, ensuring excellence in practice.

The midwives in this study felt that the number of highly anxious women they were meeting in the course of their work was increasing. While this is an anecdotal

observation it raises concerns for childbearing women, midwives and society as a whole. If this is the case midwives, as a profession, will need to gain the support, skills and knowledge to work safely with highly anxious childbearing women and ensure that their practice is effective and acceptable to our clients. Midwives involved in midwifery education need to prepare new midwives to be able to work safely with clients who are so anxious they do not respond to the negotiated boundaries and may have unrealistic expectations of their midwife.

As the themes showed the midwives were very concerned and showed great commitment to these distressed women and gained a lot of professional satisfaction from having assisted them over this time in their lives. They only handed these clients on to other midwives when the situation was untenable for them. However, the midwives did realise that persevering with these intense and demanding client relationships was at a cost to them. If midwives are finding that they are becoming worn out and disillusioned despite the usual support systems available to them such as collegial support, mentoring, and the NZCOM Midwifery Standards Review process then perhaps the concept of clinical supervision is the answer in the long term to sustain practice, enhance personal and professional development, and to ensure consumer protection. Skoberne (2003) says that midwifery can be emotionally draining and midwives can expect too much of themselves. She believes that clinical supervision should become an important part of ongoing midwifery practice for personal and professional development, even though it will sometimes be difficult and painful (Skoberne, 2003). McLardy (2003) also suggests clinical supervision as one form of support for midwives on an ongoing basis. McLardy (2003) writes, "I envisage a type of group supervision with about three midwives and a trained facilitator meeting regularly through the year to explore both their personal and work practice issues" (p. 129).

It is important for midwives to have a capacity for personal development and self-knowledge. Midwives need to be sure of their own identity and feel comfortable with themselves in order to relate to clients effectively. Guilliland (2004) believes that two of the keys to successful midwifery are self-awareness and personal security. "Rational thought struggles to take place unless there is a background of personal security. We have to know our strengths and weaknesses and be able to reflect and modify our responses appropriately" (Guilliland, 2004, p. 5).

All four of the midwives in this study found that their midwifery training did not prepare them for the realities of independent practice when dealing with maternal mental health problems. Sarah, Ellen and Anna had trained more than ten years ago and they felt that they were definitely not prepared for dealing with mothers' mental health problems. Laura was in her first year of independent practice and while she felt she had had some education it was not enough when faced with women with high levels of anxiety. She felt that how she coped with these problems was more to do with how resourceful she was as a person rather than the midwifery education she had received.

My own training in 1980 had little education on maternal mental health and I remember feeling very out of my depth at times working with distressed and anxious women. Clients like Maree and Ann challenged me and kindled my interest in learning more about maternal mental health. What I have learned in the course of my studies about anxiety, its causes and consequences, and strategies that can be employed to address it, I feel I should have known a long time ago. Maternal anxiety, as the research indicates, has a detrimental effect on families and children. Many of my past clients in the hospital and in the community would have fared better if I had had more knowledge about anxiety and maternal mental health problems in general.

When looking at the problem of PND, which has a component of high anxiety, research has found that detection rates do not reflect the rates of depression and that 80% of women with PND do not seek help (Littlewood & McHugh, 1997). Beck & Gable (2000) say, "a striking feature of this mood disorder is how covertly it is experienced" (p. 272). Seeley, Murray & Cooper (1996), found that over 40% of the depressed mothers in the United Kingdon were not identified as depressed by their Health Visitors. They found that a group of women who were cared for by Health Visitors who had extra training in detecting and supporting women with PND had a significant reduction in symptoms when compared to a group of depressed mothers who received the standard care. Since learning more about anxiety, depression and post-traumatic-distress disorder I am now more aware of what women are saying to me and have more confidence addressing the psychological and emotional aspects of childbearing.

Society and the media often portray a conformist stereotype of motherhood as being blissful happiness, contentment and fulfilment (Alcock & Nolan, 1997). Mothers with mental illness are often ashamed of how they are feeling, are ashamed of not coping

with motherhood and do not want to be judged as 'bad mothers' (Mauthner, 1997). There is still a social stigma around having a mental illness and some women are reluctant to admit that they are having problems (Mauthner, 1997). Some of the women in the midwives' stories refused to be referred to a mental health professional.

Mauthner (1997) explored women's experiences of PND and found that the majority of women in her study were disappointed with the help they received from their health professionals because they failed to pick up their depression or dismissed their feelings. The women emphasised the need for health professionals to know about PND. Beck (1995a) in a phenomenological study found seven themes that illustrated nurses' caring for mothers with PND, the first two being, having enough knowledge of PND and using astute observation and intuition to detect PND.

Continuous professional development is an expected standard of practice (NZCOM, 2002). We need to continuously build our skills and knowledge so that we can effectively care for our clients in a holistic manner. This is especially important when, as the midwives said, some of the maternal mental health services are stretched and unable to respond to referrals for up to four weeks. Early detection and prompt referral will help to reduce the woman's anxiety levels and her need for increasing amounts of care and support, and will decrease the risk to her baby.

Midwives also need to become familiar with their local maternal mental health professionals and build effective working relationships to facilitate referrals and effective collaborative care. The midwives in this study said that once a mental health professional was involved, and the client was receiving their care and support, the situation improved for the client and the midwife.

Given the destructive effect of unchecked anxiety midwives may find it helpful to develop their counselling and assessment skills and learn to use screening tools to aid the detection of mental health problems. They could also learn to support anxious women with complementary therapies and relaxation techniques. Tiran and Chummun (2004) say massage, reflexology, acupuncture, yoga, tai chi and qi gong, hypnotherapy, aromatherapy, and therapeutic touch are complementary therapies that can help reduce stress in pregnancy. Midwives should also learn what is available in the local community as anxious clients who are not well supported by family and friends may benefit from support provided by private mental health professionals, complementary

therapy professionals, anxiety support groups, and voluntary agencies and parents groups.

Alcock and Nolan (1997) argue:

> Given the close scrutiny afforded to pregnant and newly delivered women, early detection of mental health problems should be relatively easy. Early intervention is helpful and midwives are in a key position to detect early onset disorder and initiate appropriate remedial action. (p. 27)

Continuous professional development about maternal mental health will ensure that we have enough knowledge to ensure our practice is effective, acceptable and based on the best evidence available. Campbell (2002) writes, "as midwives we have a professional responsibility to understand and be current with the latest evidence in relation to things that may affect a women or her baby's health during pregnancy, labour, birth and postnatal" (p. 10).

LOOKING TO THE FUTURE

"Midwifery is a profession concerned with the promotion of women's health. It is centred upon sexuality and reproduction and an understanding of women as healthy individuals progressing through the life cycle" (NZCOM, 2002, p. 3).

Anxiety during childbearing is a major public health threat. Jean Robinson (2002) is an honorary research officer for the Association for Improvements in the Maternity Services (AIMS) in England. She writes:

> Many of those hyperactive children who are plaguing teachers, shopkeepers and bus drivers didn't get that way just because they eat food additives, have absent dads, feckless mothers, or rotten schools. It could also be because their development was affected by constant bombardment from the stress hormones in their mother's bloodstream. (p. 410)

Pregnancy presents midwives with an opportunity to give women and their families health advice and education (Campbell, 2002). Public education on maternal mental health needs to be ongoing so that families can recognise when mothers may need help. Promoting good mental health, giving information freely and frankly, and establishing realistic expectations of motherhood with women is good practice (Adams, 1997). Assisting women and their families through the adjustments and role transitions that giving birth brings, and assisting those around the new mother to be able to respond to her needs appropriately and support her in the transition, is what midwifery is about

(Bott, 1999). Antenatal education may need to focus more on parenting, coping and communication than on birth (Buist, 2003) and midwives should not be afraid to give specific and frank information on maternal mental illness (Mauthner, 1997).

After listening to the midwives stories it is apparent this was easier said than done. As McLardy (2003) says, "midwifery is not for the faint hearted" (p. 125). As midwives we often cannot fix the problems our clients have that are causing the anxiety especially, poverty, sexual abuse, previous traumatising births, difficult partner relationships, ongoing mental illness, social isolation, to name but a few. We can support, inform and advocate for women and refer them others who can help them with their problems but it is the woman who has to make the decisions and changes at a time when she most needs to be supported and cared for. For some women this is so hard. Midwifery support can often make a difference to women facing decisions and contemplating change. For midwives to provide this amount of support midwives, employers, the College of Midwives and policy makers need to give midwives education and ongoing support to achieve the level of care expected with out exhausting the midwifery workforce.

Midwifery does need to demonstrate that we are able to make a difference to the public health outcomes of women, children and families. We do need to work to ameliorate the high levels of anxiety that some of our clients experience. Especially if, as the midwives in this study observed, the number of highly anxious women is increasing.

Working with highly anxious women was challenging for the midwives in their every day practice. Midwifery needs to explore and research these challenges further so strategies can be identify to over come them and anxiety in childbearing women can be addressed. While we need our care to be effective for the anxious women, we must work out ways for midwives to cope safely with the woman's increased needs for support. We need to advocate for these vulnerable women at a policy and political level to ensure that they have services that are designed and resourced to address anxiety in the childbearing years. We also need to lobby for more support for the midwives who are providing care for women who have complex needs. I thought it was interesting that none of the midwives bought up the subject of funding for women with complex mental health needs despite the fact that anxious women often received an extraordinary amount of care and attention. The funding formula for LMC midwives for providing care for women with mental health problems needs to be reviewed.

Finally society, particularly western society, needs to take a long hard look at how they fund, resource and support women and families during the childbearing process. The trend to move away from supportive family networks in order to 'get on' in life in our society did concern the midwives in this study, as a lot of the highly anxious women were without supportive family and friends near by and they and their partners put in many hours at work. Putting financial gain and career advancement ahead of supportive family and community networks often caused social isolation and exhaustion for childbearing couples.

The evidence does point to the cause of maternal mental illness being based in social adversity and a previous history (Cooper & Murray, 1998). While progress has been made, society needs to continuously work on problems that are destructive to families and cause stress to mothers, such as relieving poverty and social isolation, reducing family violence, sexual abuse and drug and alcohol abuse and improving services to those with mental illness. Robinson (2002) writes, "politicians and social workers should stop blaming mothers and start exploring how society can provide the kind of support which women themselves define as supportive" (p. 419). Robinson (2002) ends her strongly worded article with, "Oh, and by the way, anyone who starts lecturing and blaming women for their own anxiety and anger and helplessness, is going to get a swift riposte from AIMS" (p. 419).

CONCLUSION

There is a significant amount of evidence that demonstrates the danger of unchecked anxiety to childbearing women and their children. This study has highlighted the difficulties that Sarah, Ellen, Laura and Anna experienced while trying to provide effective care for highly anxious child bearing women. The relationships with these women were intense and stressful for the midwives and the women often do not respect the boundaries that were agreed on at the beginning of the relationship protect the woman and her midwife. The midwives were committed to these anxious women and gave extraordinary amounts of support. They gained a lot of professional satisfaction and believed that their care did make a difference to the woman's childbearing experience but this was often at great expense to the midwife. The midwives did feel ill prepared by their training for the realities of caring for women with mental illness.

The midwives found the support from other midwives in their group practices and work environments vital. They found poor inter professional support and information sharing from allied maternity health professionals increased their stress when trying to cope with women with mental health problems. A major source of stress they experienced was in the difficulties they encountered trying to refer highly anxious clients to mental health services. Some of the women did not want to see a mental health professional and if they did, sometimes they did not fit the criteria for referral, or there were delays in getting assessed and treated.

I am very concerned for the health and safety of midwives working under such difficult circumstances. Midwives need to practice high levels of self care because they are their best asset. Midwifery educators need to educate student midwives about maternal mental health to a level where they can go out into practice and work safely and effectively with women with high levels of anxiety. Professional organizations that represent midwives, especially the New Zealand College of Midwives, need to monitor and care for their members. They need to lobby for accessible continuing education and funded support, such as ongoing and regular clinical supervision. They also need to ensure that philosophies, practice principles and standard of practice are protective of the midwives as well as the women. As McLardy (2003) says, "the pressures on midwives to provide the highest quality nurturing of their clients onto motherhood cannot be allowed to completely subsume midwives' own needs" (p. 129).

Maternity services in New Zealand need to be funded and resourced so that women receive acceptable and appropriate care, and midwifery practice is a sustainable and enjoyable career. Midwifery will always be complex and challenging, but it should not be structured in a way that it wears midwives out. Recruitment and retention of an expert midwifery work force is paramount. Society needs to look at how it treats women, families, and those who support and work with them. Our future depends on the babies of today.

I wish to thank Sarah, Ellen, Laura and Anna for giving me their time and openly sharing their experiences of caring for highly anxious childbearing women. Midwifery learns and grows from sharing and reflecting. Pain and stress indicate a need for change. Midwifery and society need to look at changes that should be made so midwifery is a sustainable and enjoyable career and childbearing women receive the care and support they need.

APPENDICES

APPENDIX 1: ETHICAL APPROVAL

VICTORIA UNIVERSITY OF WELLINGTON
Te Whare Wananga o te Upoko o te Ika a Maui

MEMORANDUM

DATE: May 12, 2004

TO: Maureen Hammond

FROM: Dr Allison Kirkman, Convener, Human Ethics Committee

SUBJECT: APPLICATION FOR ETHICAL APPROVAL: No 21/2004
Midwives' experiences of working with highly anxious
childbearing women.

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved and this approval continues until 28 February 2005. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Allison Kirkman
Convener

Participant Information Sheet

Study: Midwives' experiences of working with highly anxious childbearing women.

Researcher: Maureen Hammond   **Supervisor:** Dr Christine Alavi

I am a Masters student in the Graduate School of Nursing and Midwifery at Victoria University of Wellington. As part of this degree I am undertaking a research project leading to a thesis. The project I wish to undertake is to look at midwives' experiences of working with childbearing women who are experiencing high levels of anxiety. This research has been approved by the Human Ethics Committee of Victoria University of Wellington.

I invite you to participate in this research project. I plan to interview midwives about their experiences of working with highly anxious childbearing women and then look for common themes that describe the experience.

The interview will take place in a place of your choice and at a time convenient to you and will last approximately 1hour or until you feel you have described your experiences. The interview will the audiotaped and then transcribed by a professional transcriber. The transcriber has signed a confidentially agreement.

All data from the interviews will be kept confidential and stored in a secure place. Your identity will be protected and any names used in the report will be pseudonyms. I also undertake not to discuss with anyone your identity or where you work.

I will return to you a copy of your transcript along with the initial emergent themes from the data analysis for you to comment on before the final analysis is done so that your reflections and insights can be considered in the final analysis. This will require a follow up phone call and discussion.

This research project and the results will be written up in the form of a thesis, submitted to the Graduate School of Nursing and Midwifery for marking and then published as the final requirement to complete my Master of Arts Degree (applied) in Midwifery. The thesis will be placed in the university library. You will be given an opportunity to review the final report before it is finally submitted. I intend to submit the findings in the form of an article to professional midwifery journals for publication.

Should you feel the need to withdraw from the project you may do so at any time before the data is analysed. Just let me know, it will not be a problem. All interview tapes will be offered back to participants otherwise will be wiped. Transcripts, notes and files containing data will be kept in a secure place for 10 years then destroyed.

For further information contact me on 04-902-3642 or 027-2731-292, or
Dr Christine Alavi on 04-463-6135 at the Graduate School of Nursing and Midwifery, Victoria University of Wellington, PO Box 600, Wellington.

Maureen Hammond: _____   Date: _____

APPENDIX 3: RESEARCH PARTICIPATION CONSENT

Consent to Participation in Research

Title of project: Midwives' experiences of working with highly anxious childbearing women.

Researcher: Maureen Hammond: Masters student of the Graduate School of Nursing and Midwifery at Victoria University of Wellington.

Supervised by: Dr Christine Alavi: Associate Professor at the Graduate School of Nursing and Midwifery, Victoria University of Wellington.

I _____have agreed to participate in the above research project. I have been given and understand an explanation of this research project. I am happy to be interviewed and am willing to share my experiences of caring for highly anxious childbearing women.

I understand that:
- Information I provide will be kept confidential to the researcher, the supervisor and the person who transcribes the tape recordings of my interview
- The published results will not use my name. A pseudonym will be used when referring to information I give or opinions I express.
- I will have my taped interview transcript and the initial themes that emerge from the data returned to me for my comment so that my reflections and insights can be considered in the final analysis. I understand that this will be done in writing and by a follow-up telephone call.
- I will have the opportunity to read the final report before it is submitted as a thesis for marking.
- The thesis will be lodged in the library at Victoria University of Wellington.
- The researcher intends to submit a research report in the form of an article for publication to professional midwifery journals.
- I will be free to withdraw from the project any time before the data is analysed.
- I understand that the tape recording of interviews will be electronically wiped at the end of the project unless I indicate that I would like it returned to me.
- All transcripts, files and notes generated by this project will be kept in a secure place for 10 years then destroyed.
- I will be entitled to a copy of the final published thesis.

Signed: _____   Date: _____

APPENDIX 4: INITIAL THEMES

Initial main themes and sub themes that illustrate the midwives' experiences of working with highly anxious child bearing women.

1   Challenging client-midwife partnerships

- Intense relationship
- Needing more time
- Receiving more phone calls from client
- Receiving more 'out of hours' phone calls
- Trust slow to develop
- Clients withhold important information
- Clients reluctant to receive care from back up midwife
- Clients experience more physical symptoms
- Clients have narcissistic tendencies - do not appreciate midwife has to eat and sleep, care for other clients and have a personal life
- Midwife endeavouring to negotiate boundaries to relationship to protect herself, her practice partners and her family from clients demands
- Difficult to terminate relationship at 6 weeks
- midwife experiences stress and questions her career choice
- poor collegial support and lack of information sharing from allied maternity care providers e.g. GP's, hospital staff, mental health providers increases midwives stress levels

2   Making a difference

- Midwives felt deep sense of commitment to anxious women – despite challenging partnerships
- Prepared to persevere with relationship if has good rapport
- Midwives experienced satisfaction believing they can made a difference
- Taking more time
- Doing more visits
- Giving, repeating and clarifying information
- Ensuring informed choice
- Building confidence
- Advocating for clients to ensure appropriate care in hospital
- Careful assessments and continuous monitoring – because of increased complaints of physical symptoms – afraid of missing something
- Being understanding
- Feeling empathy

- Demonstrating patience

- Giving support and encouragement

3   Realizing own limitations

- Enlisting assistance of other midwives to help care for anxious clients.

- Debriefing with midwifery colleagues

- Feeling that midwifery training did not prepare them for dealing with maternal mental health problems

- Seeking professional development

- Seeking more information from client's medical records, and previous or current allied health professionals e.g. GP, Plunket

- Referring client to specialist mental health care

- Feeling concern and stress when: unable to gain access to specialist help within appropriate time frames; client does not wish to be referred; client does not fit criteria for referral

- Knowing when to assist the client to find another LMC because the midwife is unable to develop a rapport or unable to meet that particular clients needs due to work load or personal life demands at that time

APPENDIX 5: FURTHER ANALYSIS

1   Challenging client-midwife partnerships

- Experiencing intense relationships
    - i   Intense relationships
    - ii   Needing more time
    - iii   Receiving more phone calls from clients
    - iv   Receiving more 'out of hours' phone calls
    - v   Clients experience more physical symptoms
    - vi   Clients have narcissistic tendencies – do not appreciate midwife has to eat and sleep, care for other clients and have a personal life
    - vii   Trust slow to develop
    - viii Clients withhold important information
    - ix   Clients reluctant to receive care from back up midwife
    - x   Difficult to terminate relationship at 6 weeks
- Experiencing stress
    - i   Midwife experiences stress and questions her career choice
    - ii   Poor collegial support and lack of information sharing from allied maternity care providers e.g. GP's, hospital staff, mental health providers increases midwives stress levels
- Forming boundaries
    - i   Midwife endeavours to negotiate boundaries to relationship to protect herself, her practice partners and her family from clients demands

2   Making a difference

- Showing commitment
    - i   Midwives felt deep sense of commitment to anxious women – despite challenging partnerships
    - ii   Prepared to persevere with relationship if has good rapport
    - iii   Taking more time
    - iv   Doing more visits
    - v   Careful assessments and continuous monitoring – because of increased complaints of physical symptoms – afraid of missing something
- Giving support
    - i   Giving support and encouragement
    - ii   Building confidence
    - iii   Being understanding

      iv   Feeling empathy

      v   Demonstrating patience

      vi   Advocating for clients to ensure appropriate care in hospital

      vii   Giving, repeating and clarifying information

      viii Ensuring informed choice

- Experiencing professional satisfaction

      i   Midwives experienced satisfaction believing they can make a difference

3   Realising own limitations

- Seeking peer support

      i   Enlisting assistance of other midwives to help care for anxious clients

      ii   Debriefing with midwifery colleagues

- Experiencing lack of knowledge

      i   Seeking more information from client's medical records, and previous or current allied health professionals e.g. GP, Plunket

      ii   Feeling that midwifery training did not prepare them for dealing with maternal mental health problems

      iii   Seeking professional development

- Referring client on for further care

      i   Knowing when to assist the client to find another LMC midwife because the midwife us unable to develop a rapport or unable to meet that particular clients needs due to work load or personal life demands at that time

      ii   Referring client to specialist mental health care

      iii   Feeling concern and stress when: unable to gain access to specialist help within appropriate time frames; client does not wish to be referred: client does not fit criteria for referral

REFERENCES

Adams, M. (1997). The challenge of mental health promotion. In H. Crafter, *Health promotion in midwifery: principles and practice* (pp. 229-260). London: Arnold.

Alcock, G., & Nolan, P. (1997). Maternal mental health 1 – puerperal psychosis. *Modern Midwife,* 7 (12), 27-30.

Andersson, L., Sundstrom-Poromaa, I., Bixo, M., Wulff, M., Bondestam, K., & Astrom, M. (2003). Point prevalence of psychiatric disorders during the second trimester of pregnancy: a population-based study. *American Journal of Obstetrics & Gynecology,* 189 (1), 148-54.

Armstrong, D., & Hutti, M. (1998). Pregnancy after perinatal loss: the relationship between anxiety and prenatal attachment. *JOGNN: Journal of Obstetric Gynecologic and Neonatal Nursing,* 27 (27), 183-9.

Axe, S. (2000). Labour debriefing is crucial for good psychological care. *British Journal of Midwifery,* 8 (10), 626-631.

Barlow, D.H. (2002). *Anxiety and its disorders: the nature and treatment of anxiety and panic* (2nd ed). New York: Guilford Press.

Barnes, M. (1999). Research in midwifery: the relevance of a feminist theoretical framework. *Journal of Australian College of Midwives,* 12 (2), 6-10.

Beck, C.T. (1992). The lived experience of postpartum depression: a phenomenological study. *Nursing Research,* 41 (3), 166-170.

Beck, C.T. (1995a). Perception of nurses' caring by mothers experiencing postpartum depression. *JOGNN Journal of Obstetric, Gynaecologic and Neonatal Nursing,* 24 (9), 819-825.

Beck, C.T. (1995b). The effects of postpartum depression on maternal-infant interaction: A meta-analysis. *Nursing Research,* 44 (5), 298-304.

Beck, C.T. (1996a). Postpartum depressed mothers' experiences interacting with their children. *Nursing Research,* 45 (2), 98-104.

Beck, C.T. (1996b). A meta-analysis of predictors of postpartum depression. *Nursing Research,* 45 (5), 297-303.

Beck, C.T. (1998). The effects of postpartum depression on child development: a meta-analysis. *Archives of Psychiatric Nursing,* 12 (1), 12-20.

Beck, C.T., & Gable, R.K. (2000). Postpartum depression screening scale: development and psychometric testing. *Nursing Research*, 49 (5), 272-282.

Bloch, M., Schmidt, P.J., Danaceau, M., & Murphy, J. (2000). Effects of gonadal steroids in women with a history of postpartum depression. *The American Journal of Psychiatry,* 157 (6), 924-930.

Bott, J. (1999). Reflections on postnatal depression. *British Journal of Midwifery,* 7 (1), 45-48.

Brayton, J. (1997). What makes feminist research feminist? The structure of feminist research within the social sciences. Retrieved June 6, 2003 from http://www.unb.ca/web/PAR-L/feminmethod.htm

Browne, L. (2004). Caring for the midwife. Paper presented at the New Zealand College of Midwives 8th Biennial National Conference, Wellington, New Zealand.

Buist, A. (2003). Promoting positive parenthood: emotional health in pregnancy. *Australian Midwifery Journal*, 16 (1), 10-14.

Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse Education Today,* 11 (6), 461-466.

Campbell, N. (2002). Midwifery advisor's column. *Midwifery News*, 26, 10.

Chan, S.W., Levy, V., Chung, T.K.H., & Lee, D. (2002). A qualitative study of the experiences of a group of Hong Kong Chinese women diagnosed with postnatal depression. *Journal of Advanced Nursing,* 39 (6), 571-9.

Charles, C. (1997). Post-traumatic stress disorder. *Midwives,* 110 (1317), 250-252.

Clemmens, D.A. (2000). Adolescent mothers' depression after the birth of their babies: weathering the storm. *Adolescence,* 37 (147), 551-65.

Cluett, E.R., & Bluff, R. (2000). *Principles and practice of research in midwifery.* Edinburgh: Harcourt Publishers.

Collier, J. (1996). Postnatal depression. *Primary Healthcare New Zealand,* February, 95-98.

Cooper, P.J., & Murray, L. (1998). Postnatal depression. *British Medical Journal,* 316 (7138), 1884-1889.

Cox, J. (1986). *Postnatal depression: a guide for health professionals.* Edinburgh: Churchill Livingstone.

Cox, J.L., Holden, M., & Sagovsky, R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786.

Cote-Arsenault, D., Bidlack, D., & Humm, A. (2001). Women's emotions and concerns during pregnancy following perinatal loss. *MCN: American Journal of Maternal Child Nursing,* 26 (3), 128-134.

Creedy, D. (1999). Postnatal depression and post traumatic stress disorder: What are the links? *Birth Issues,* 8 (4), 125-130.

Crompton, J. (2002). Post-traumatic stress disorder and childbirth. *New Zealand College of Midwives Journal,* 26, 17-19.

Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process.* Australia: Allan & Unwin.

Davies, D. (1998). Embracing the past, understanding the present, creation the future: feminism and midwifery. New Zealand College of Midwives conference, Auckland, New Zealand.

Denzin, N.K., & Lincoln, Y.S. (2000). *The handbook of qualitative research.* Thousand Oaks, CA: Sage Publications.

Derbyshire, F. (2000). Clinical supervision within midwifery. In M. Kirkham (Ed), *Developments in the supervision of midwives* (pp. 167-196). Oxford: Books for Midwives.

Dewey, K.G. (2001). Maternal and fetal stress are associated with impaired lactogenesis in humans. *Journal of Nutrition,* 131 (11), 3012s-5s.

Dion, X. (2002). Anxiety: a terrifying facet of postnatal depression. *Community Practitioner,* 75 (10), 376-380.

Dozor, J. (2001). Working with difficult clients. Retrieved September, 18, 2003 from http://www.midwiferytoday.com/articles/difficultclients.asp?a=1&r=1&e=1&q=difficult

Durie, M.H. (1996, February). Characteristics of Maori health research. Paper presented at the Hui Wakapiripiri, Hongoeke Marae.

Draper, J. (1997). Potential and problems: the value of feminist approaches to research. *British Journal of Midwifery,* 5 (10), 597-600.

Emden, C. (1998). Conducting a narrative analysis. *Collegian,* 5 (3), 34-39.

Engel, C. (2003). Towards a sustainable model of midwifery practice in a continuity of carer setting: the experience of New Zealand midwives. *New Zealand College of Midwives Journal,* 28, 12-15.

Enkin, M., Keirse, M.J.N.C., & Chalmers, I. (1989). *A guide to effective care in pregnancy and childbirth.* Oxford: Oxford University Press

Erlen, J.A., & Jones, M. (1999). The patient no one liked. *Orthopaedic Nursing,* 18 (4), 76-79.

Evans, J., Heron, J., Francomb, H., Oke, S., & Goulding. (2001). Cohort study of depressed mood during pregnancy and after childbirth. *British Medical Journal,* 323 (7307), 257-260.

Fontana, A., & Frey, J.H. (2000). The interview: from structured questions to negotiated text. In N.K. Denzin & Y.S. Lincoln (Eds). *Handbook of qualitative research* (2nd ed) (pp. 645-672). Thousand Oaks, CA: Sage Publications.

Fowles, E. (1998). The relationship between maternal role attainment and postpartum depression. *Health Care for Women International,* 19, 83-94.

Franks, M. (2002). Feminisms and cross-ideological feminist social research: standpoint, situatedness and positionality – developing cross-ideological feminist research. Retrieved June 6, 2003 from http:www.bridgrew.edu/Depts/ARTSCNCE/JIWS/June02/feministsocialresearch.pdf

Gitau, R., Cameron, A., Fisk, N.M., & Glover, V. (1998). Fetal exposure to maternal cortisol. *The Lancet,* 352 (9129), 707-8.

Gilligan, G. (1993). *In a different voice: psychological theory and women's development* (2nd ed). Massachusetts: Harvard University Press.

Gillis, A., & Jackson, W. (2002). *Research for nurses: methods and interpretation.* Philadelphia: F.A. Davis.

Graham, D. (1997). The effects of stress on the childbearing woman and her family. *British Journal of Midwifery,* 5 (2), 82-85.

Greig, J. & Sahar, M. (1997). *Post-natal distress survival guide.* Wellington: Post and Ante-Natal Distress Support Group (Wgtn.)

Groome, L.J., Swiber, M.J., Bentz, L.S., Holland, S.B., & Atterbury, J.L. (1995). Maternal anxiety during pregnancy: effect on fetal behaviour at 38 to 40 weeks of gestation. *Journal of Developmental & Behavioral Pediatrics,* 16 (6), 391-6.

Gross, D., Conrad, B., Fogg, L., Willis, L., & Garvey, C. (1995). A longitudinal study of maternal depression and preschool children's mental health. *Nursing Research,* 44 (2), 96-100.

Guilliland, K., & Pairman, S. (1995). *The midwifery partnership. A model for practice.* Monograph Series: 95/1. Department of Nursing and Midwifery. Victoria University of Willington.

Guilliland, K. (2004). A hundred years of midwifery and what have we learnt about ourselves? *Midwifery News,* 34, 4-6 & 28-29.

Hall, J.M., & Stevens, P.E. (1991). Rigor in feminist research. *Advances in Nursing Science,* 13 (3), 16-29.

Harding, J. (1986). *Perspectives on gender and science.* Lewes: Falmer Press.

Health Research Council of New Zealand. (1998). Maori health research themes. Retrieved March 25, 2003, from http://www.hrc.govt.nz/themes.htm

Henderson, J.J., Evans, S.F., Straton, J.A.Y., Priest, S.R., & Hagan, R. (2003). Impact of postnatal depression on breastfeeding duration. *Birth,* 30 (3), 175-80.

Holden, J.M. (1990). Chapter 3, Emotional problems associated with childbirth. In J. Alexander, V. Levy, & S. Roach (Eds.) *Postnatal care: a research-based approach.* London: MacMillan.

Hollway, W, & Jefferson, T. (2000). *Doing qualitative research differently: free association, narrative and the interview method.* London: Sage Publications

Hughes, P.M., Turton, P., & Evans, C.D.H. (1999) Stillbirth a risk factor for depression and anxiety in the subsequent pregnancy: cohort study. *British Medical Journal,* 318 (7200), 1721-4.

Hunt, C.J., Andrews, G., & Sumish, H.J. (1995). *The management of mental disorders: Vol 4. Hand book for the anxiety, stress-related and somatoform disorders.* Sydney: World Health Organization.

Jebali, C. (1993). A feminist perspective on postnatal depression. *MIDIRS Midwifery digest,* 3 (2), 203-205.

Johnson, T.R.B., & Apgar, B. (n.d.) Women's primary health grand rounds at the University of Michigan: postpartum depression. Retrieved March 17, 2003 from www.obgyn.net/femalepatient/?page=leopold.

Katz Rothman, B. (1989). *Recreating motherhood: ideology and technology in a patriarchal society*. W.W. Norton & Company: New York

Kirkham, M. (1986). A feminist perspective in midwifery. In C. Webb (Ed.), *Feminist practice in women's health care* (p. 35-49). Chichester: John Wiley & Sons.

Kit, L.K., Janet, G., & Jegasothy, R. (1997). Incidence of postnatal depression in Malaysian women. *Journal of Obstetrics & Gynaecology Research,* 23 (1), 85-9.

Kvale, S. (1996). *Interviews: an introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage Publications.

Leonard, L.G. (1998). Depression and anxiety disorders during multiple pregnancy and parenthood. *JOGNN: Journal of Obstetric Gynaecologic and Neonatal Nursing,* 27 (3), 329-336.

Lesesne, C.A., Visser, S.N., & White, C.P. (2003). Attention-deficit/hyperactivity disorder in school-aged children: association with maternal mental health and use of health care resources. *Pediatrics,* 111(5 Part 2), 1232-7.

Letherby, G. (2003). *Feminist research in theory and practice.* Buckingham: Open University Press.

Littlewood, J., & McHugh, N. (1997). *Maternal distress and postnatal depression: the myth of madonna.* London: MacMillan Press Ltd.

Logsdon, M.C., Birkimer, J.C., & Usil, W.M. (2000). The link of social support and postpartum depressive symptoms in African-America women with low incomes. *MCN: American Journal of Maternal Child Nursing,* 25 (5), 262-266.

Lou, H.C., Hansen, D., Nordentoft, M., Pryds, O., Jensen, F., Nim, J., & Hemmingsen, R. (1994). Prenatal stressors of human life affect fetal brain development. *Developmental Medicine & Child Neurology,* 36 (9), 826-32.

Lyth, G.M. (2000). Clinical supervision: a concept analysis. *Journal of Advanced Nursing,* 31 (3), 722-729.

Mander, R. (2001). *Supportive care and midwifery.* London: Blackwell Science.

Marcus, M.T., & Liehr, P.R. (1998). Qualitative approaches to research. In G LoBiondo-Wood & J Haber (Ed.), *Nursing research: methods, critical appraisal and utilisation* (pp. 215-244) (4th ed.). St Louis: Mosby.

Mauthner, N.S. (1997). Postnatal depression: how can midwives help? *Midwifery*, 13, 168-171.

Mauthner, N., & Doucet, A. (1998). Reflections on a voice-centred relational method: Analysing maternal and domestic voices. In J. Bibbens, & R. Edwards (Eds.), *Feminist dilemmas in qualitative research: public knowledge and private lives* (119-146). London: Sage Publications.

McCormack, T. (1989). Feminism and the new crisis in methodology. In W Tomm (Ed.) *The effect of feminist approaches on research methodologies* (pp. 13-29). Canada: Wilfrid Laurier University Press.

McGill, H., Burrows, V.L.B., Holland, L.A., Langer, J.G., & Sweet, M.A. (1995). Postnatal depression: a Christchurch study. *New Zealand Medical Journal,* 108 (999), 162-164.

McLardy, E. (2003). *On call 24/7: Midwives negotiation home and work boundaries.* Unpublished MA thesis, Victoria University of Wellington, Wellington.

McMahon, C., Barnett, B., Kowalenko, N., Tennant, C., & Don, N. (2001). Postnatal depression, anxiety and unsettled infant behaviour. *Australian & New Zealand Journal of Psychiatry,* 35 (5), 581-8.

Meighan, M., Davis, M.W., Thomas, S. P., & Droppleman, P.G. (1999). Living with postpartum depression: the father's experience. *MCN, American Journal of Maternal Child Nursing,* 24 (4), 202-8.

Melender, H., & Lauri, S. (1999). Fears associated with pregnancy and childbirth: experiences of women who have recently given birth. *Midwifery,* 15 (3), 177-82.

Monk, C., Myers, M.M., Sloan, P.R., Ellman, L.M., & Fifer, W.P. (2003). Effects of women's stress-elicited physiological activity and chronic anxiety on fetal heart rate. *Journal of Developmental & Behavioral Pediatrics,* 24 (1), 32-8.

Nahas, V.L., Hillege, S., & Amashe, N. (1999). Postpartum depression. The lived experiences of middle eastern migrant women in Australia. *Journal of Nurse-Midwifery,* 44 (1), 65-74.

Nicolson, P. (1998). *Post-natal depression: psychology, science and the transition to motherhood.* London: Routledge.

Newcomer, J.W., Selke, G., Melson, A.K., Hershey, T., Craft, S., Richards, K., & Alderson, A.L (1999). Decreased memory performance in healthy humans induced by stress-level cortisol treatment. *Archives of General Psychiatry.* 56 (6), 527-33.

New Zealand College of Midwives. (2002). *Midwives handbook for practice* (rev. ed.). Christchurch: Author.

Nursing Council of New Zealand. (1996). *Guidelines for cultural safety in nursing and midwifery education.* Wellington:Author.

Oakley, A. (1992). *Social support and motherhood.* Oxford: Blackwell

Oakley, A. (2000). *Experiments in knowing: gender and method in the social sciences.* England: Polity Press.

Oakley, A. (n.d.). Women's health matters. Retrieved May 27, 2004 from http://www.womenshealthmatters.ca/interviews/interview_show.cfm?number=32

Oates, M. (2002). Adverse effects of maternal antenatal anxiety on children: causal effect or developmental continuum? *British Journal of Psychiatry,* 180, 478-479.

O'Connor, T.G., Heron, J., Golding, J., Beveridge, M., & Glover, V. (2002). Maternal antenatal anxiety and children's behavioural/emotional problems at 4 years. *British Journal of Psychiatry,* 180, 502-508.

O'Connor, T.G., Heron, J., Goulding, J., & Glover, V. (2003). Maternal antenatal anxiety and behavioural/emotional problems in children: a test of a programming hypotheses. *Journal of Child Psychology & Psychiatry & Allied Disciplines,* 44 (7), 1025-36.

Page, L.A. (2000). *The new midwifery: science and sensitivity in practice.* Edinburgh: Churchill Livingstone.

Pairman, S. (1999). Partnership revisited: towards midwifery theory. *New Zealand College of Midwives Journal,* 21, 6-12.

Prince, J., & Adams, M. (1990). Chapter 8, The psychology of pregnancy. In J. Alexander, V. Levy, & S. Roach (Eds.) *Antenatal Care: A Research-Based Approach* (pp. 120-133). London: MacMillan.

Putnam Tong, R. (1998). *Feminist thought: a more comprehensive introduction.* (2nd ed). Australia: Allen & Unwin.

Ralph, K., & Alexander, J. (1994). Borne under stress. *MIDIRS Midwifery Digest*, 4 (3), 330-332.

Raphael-Leff, J. (1996). *Psychological processes of childbearing.* London: Chapman & Hall.

Reinharz, S. (1992). *Feminist methods in social research.* New York: Oxford University Press.

Robinson, J. (2002). Stress in pregnancy: effects on the child. *British Journal of Midwifery,* 10 (7), 419.

Rosser, J. (1999). Anxiety in pregnancy bad for women, bad for babies. *Practising Midwife,* 2 (5), 5.

Saisto, T., & Halmesmaki, E. (2003). Fear of childbirth: a neglected dilemma. *Acta Obstetricia et Gynecological Scandinavica,* 82 (3), 201-8.

Seeley, S., Murray, L., & Cooper, P.J. (1996). The outcome for mothers and babies of health visitor intervention. *Health Visitor,* 69 (4), 135-138.

Sjogren, B., & Thomassen, P. (1997). Obstetric outcome in 100 women with sever anxiety over childbirth. *Acta Obstetricia et Gynecological Scandinavica,* 76 (10), 948-52.

Skinner, J. (1999). Midwifery partnership: individualism, contractualism or feminist praxis? *New Zealand College of Midwives Journal,* 21, 14-17.

Skoberne, M. (2003). Supervision in midwifery practice. *Midwives,* 6 (2), 66-69.

Stanley, L., & Wise, S. (1983). *Breaking out: feminist consciousness and feminist research.* London: Routledge & Kegan Paul.

Stanley, L., & Wise, S. (1993). *Breaking Out Again: feminist ontology and epistemology.* London: Routledge.

Stein, A., Cooper, P.J., Campbell, E.A., Day, A., & Altham, P.M.E. (1989) Social adversity and perinatal complications: their relation to postnatal depression. *British Medical Journal*, 298 (6680), 1073-4.

Teixeira, J.M.A., Fisk, N.M., & Glover, V. (1999). Association between maternal anxiety in pregnancy and increased uterine artery resistance index: cohort based study. *British Medical Journal,* 318 (7177), 153-7.

Thompson, S.M., & Barrett, P.A. (1997). Summary oral reflective analysis: a method for interview data analysis in feminist qualitative research. *Advances in Nursing Science,* 20 (2), 55-65.

Tisdale, N. (1997). *Psychology of childbirth.* Hale: Books for Midwives Press.

Tiran, D. & Chummun, H. (2004). Complementary therapies to reduce physiological stress in pregnancy. *Complementary Therapies in Nursing & Midwifery,* 10 (3), 162-167.

Troutman, B., & Cutrona, C. (1990). Nonpsychotic postpartum depression among adolescent mothers. *Journal of Abnormal Psychology,* 99 (1), 69-78.

Turner, R.A., Altemus, M., Enos, T., Cooper, B., & McGuinness. (1999). Preliminary research on plasma oxytocin in normal cycling women: investigating emotion and interpersonal distress. *Psychiatry,* 62 (2), 97-113.

Ussher, J. (1991). *Women's madness: misogyny or mental illness.* USA: University of Massachusetts Press.

Victoria University of Wellington. (2001). *Human Ethics Committee guidelines.* Wellington: Author.

Wadhwa, P.D., Sandman, C.A., Porto, M., Dunkel-Schetter, C., & Garite, T.J. (1993). The association between prenatal stress and infant birth weight and gestational age at birth: a prospective investigation. *American Journal of Obstetrics & Gynecology,* 169 (4), 858-65.

Watson, J. (1988). *Nursing: human science and human care. A theory of nursing.* New York: National League for Nursing.

Weaver, J.D. (n.d.). Defusing & debriefing. Retrieved Februauy 7, 2005, from http://ourworld.compuserve.com/homepages/johndweaver/debrief.htm

Webb, C. (1993). Feminist research: definition, methodology, methods and evaluation. *Journal of Advanced Nursing,* 18 (3), 416-423.

Webster, M.L., Thompson, J.M.D., Mitchell, E.A., & Werry, J.S. (1994). Postnatal depression in a community cohort. *Australia and New Zealand Journal of Psychiatry,* 28 (1), 42-20.

Westmarland, N. (2001). The quantitative/qualitative debate and feminist research: a subjective view of objectivity. *Forum: Qualitative Social Research,* 2 (1). Retrieved June 6, 2003 from http://www.qualitative-research.net/fqs-texte/1-01/1-01westmarland-e.htm

Wheatley, S. (1998). Psychosocial support in pregnancy. In S. Clement (Ed.) *Psychological Perspectives on Pregnancy & Childbirth* (p. 45-58). London: Churchill Livingston.